

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 1/69

|   |  |  |        |   |  |  |  |
|---|--|--|--------|---|--|--|--|
| 06034   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |        |   |  | 06030  |  |
| CERTIFICATE OF DEATH  |  |  |        |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First  | Middle | Last  | 2a. DATE OF DEATH<br>Month Day Year        |  | 2b. HOUR<br>M                                |
|   |  | Milton   | Ernest | Ausherman   | April 12 1969                              |  |  |
| 3. SEX  |  | 4. RACE  |        | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)  |  |
| Male  |  | White  |        | December 3, 1881  |  | 87 YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |
| Halfway, Wash. Co. Md.  |  | USA  |        |   |  | Washington Md.   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Hagerstown  |  | Washington Co. Hospital  |        | Farmer  |  | Agriculture  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |        | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| Maryland  |  | Washington   |        | Hagerstown  |  | 2335 Jefferson Blvd.   |  |
| 14. FATHER'S NAME   |  | First  | Middle | Last  | 15. MOTHER'S MAIDEN NAME First Middle Last |  |  |
|   |  | Hamilton   | David  | Ausherman   | Julia Ann Bower                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  | 16b. SOCIAL SECURITY NO.   |        | 17. INFORMANT Address   |  |  |  |
| No  |  | None   |        | Mrs. Grace M. Ausherman 2335 Jefferson Blvd. Hagerstown, Md.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |        |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) acute bronchitis  |  |  |        |   |  |  | 2 hrs.                                       |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |        |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  |        |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |        |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL-DISEASE OR CONDITION GIVEN IN PART 1 (g)   |  |  |        |   |  |  |  |
| Mild emphysema; arteriosclerotic changes  |  |  |        |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |        | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
|   |  |  |        |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
|   |  |  |        |   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |        | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
|   |  |  |        |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 14 Jan, 1969, to 14 April, 1969, that (I) (we) last saw the deceased alive on 11 April, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |        |   |  |  |  |
| 22b. SIGNATURE<br>Richard T. Birtland   |  |  |        | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br>14 April 69  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |        | 22e. ADDRESS<br>1135 Potomac Ave, Hagerstown, Md.   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |  |
| Burial  |  | 4/15/69  |        | Rest Haven Cemetery   |  | Hagerstown-Washington Md.  |  |
| 24. FUNERAL DIRECTOR<br>Wm. C. Horst<br>Rest Haven Funeral Chapel Hagerstown, Md.   |  |  |        | ADDRESS   |  | 25a. REGISTRAR'S SIGNATURE<br>APR 16 1969  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1-69

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |  |   |  |  |   |  |  |
|---|--|--|---|--|--|---|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |  |  |   |  |  |   |  |  |
| 06035   |  |  |   |  |  |   |  |  |   |  |  |
| CERTIFICATE OF DEATH  |  |  |   |  |  |   |  |  |   |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br><b>ROSE</b>  |  |  | Middle<br><b>ADA</b>  |  |  | Last<br><b>BATES</b>  |  |  |
| 3. SEX<br><b>Female</b>   |  |  | 4. RACE<br><b>White</b>   |  |  | 5. DATE OF BIRTH<br><b>October 13, 1883</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>10</b> Year <b>1969</b>                    |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 2b. HOUR<br><b>11:55</b> M  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Hagerstown</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Garlock Nursing Home</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>At home</b>                                       |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |  | 13b. CITY OR TOWN<br><b>Washington</b>  |  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | 13e. STREET AND NUMBER<br><b>122 Bower Ave.</b>   |  |  |
| 14. FATHER'S NAME<br>First <b>George</b>  |  |  | Middle <b>Inskip</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Kezia</b>  |  |  | Middle <b>Beard</b>   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>None</b>   |  |  | 17. INFORMANT<br><b>Miss Dorothy L. Bates</b>   |  |  | Address<br><b>Hagerstown, Md.</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonitis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Arteriosclerotic cardio vascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 1/2 days</b><br><b>10 years</b> |  |  |   |  |  |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                      |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-1-</b> , 19 <b>69</b> , to <b>4-10-</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>4-10-</b> 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><i>E. W. Ditto, Jr.</i>   |  |  | DEGREE<br><b>Dr. E. W. Ditto, Jr.</b>   |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  |  | 22c. DATE SIGNED<br><b>April 11, 1969</b>   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. E. W. Ditto, Jr.</b>   |  |  | 22e. ADDRESS<br><b>215 W. Washington St., Hagerstown, Md.</b>   |  |  |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>April 13, 1969</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Hill Cemetery</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Stephens City, Frederic, Virginia</b> |  |  |
| 24. FUNERAL DIRECTOR<br><b>Albert L. Leaf</b>   |  |  | ADDRESS<br><b>Williamsport, Maryland</b>  |  |  | 25a. RECEIVED BY REGISTRAR<br>DATE<br><b>APR 15 1969</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |  |

00035

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VR A15 (1)  
30M REV. 1-69

|  |  |  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|--|--|---|--|
| 06036  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                    |  |  |  | 06032  |  |   |  |
| 1. DECEASED-NAME (Type or print) <u>Lewis Grant Bell</u>   |  |  |  |  |  | 2a. DATE OF DEATH <u>April</u> Month <u>12</u> Day <u>1969</u> Year                          |  | 2b. HOUR <u>6:42</u> M                                  |  |
| 3. SEX <u>M</u>  |  | 4. RACE <u>Wh</u>  |  | 5. DATE OF BIRTH <u>Feb. 1, 1889</u>   |  | 6. AGE (In years last birthday) <u>80</u> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country) <u>Adams Co. Pa.</u>   |  | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <u>WASHINGTON</u> Md.   |  |   |  |
| 10. CITY OR TOWN OF DEATH <u>HAGERSTOWN</u>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>WESTERN MD. STATE HOSPITAL</u> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Labor</u>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>  |  | 13b. COUNTY <u>Frederick</u>   |  | 13c. CITY OR TOWN <u>Emmitsburg</u>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER <u>South Seton Ave.</u>          |  |
| 14. FATHER'S NAME First <u>John</u> Middle <u>Bell</u> Last <u>Bell</u>  |  | 15. MOTHER'S MAIDEN NAME First <u>Jane</u> Middle <u>Overholtzer</u> Last <u>Overholtzer</u>                   |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO. <u>220-05-6293</u>  |  | 17. INFORMANT Address <u>Mrs. Frances Rosensteel, Emmitsburg, Md.</u>  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Lobular pneumonia</u><br><u>4123</u> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> years<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerosis</u> years<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5d</u>  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7-29, 1965</u> , to <u>4-12, 1969</u> , that (I) (we) last saw the deceased alive on <u>4-12, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE <u>Edwin G. Riley MD</u>  |  | 22c. DATE SIGNED <u>4-12-69</u>  |  | 22d. PHYSICIAN'S NAME (Type) <u>Edwin G. Riley</u>   |  |  |  |   |  |
| 22e. ADDRESS <u>1500 Penna, Hagerstown, Md.</u>  |  |  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 23b. DATE <u>April 15, 1969</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt View</u>  |  | 23d. LOCATION (City or Town) (County) (State) <u>Emmitsburg, Frederick Co. Md.</u>           |  |   |  |
| 24. FUNERAL DIRECTOR <u>Clarence E. Wilson</u>   |  | ADDRESS <u>Emmitsburg, Md.</u>   |  | 25a. REC'D BY REGISTRAR <u>APR 16 1969</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |  |   |  |

00030

RECEIVED

U.S. DEPARTMENT OF AGRICULTURE

April 12 1914

Leaves (Front)

M

|   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |     |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|

U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |         |                              |  |  |   |   |   |   |  |
|--|---------|------------------------------|--|--|---|---|---|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |                              |  |  |   |   |   |   |  |
| 1. DECEASED-NAME<br>(Type or Print)  |         |                              | First Middle Last  |  |   | 2a. DATE KNOWN OF DEATH   |   |   | 2b. HOUR                                     |
| William Stewart Blevins  |         |                              |  |  |   | Month Day Year  |   |   | April 30, 1969                               |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (in years last birthday)  | IF UNDER 1 YEAR  |   | IF UNDER 24 HRS.  |   | 2c. DATE PRONOUNCED DEAD  |  |
| Male   | White   | August 1, 1908               | 60 YRS.  | MONTHS   | DAYS  | HOURS   | MIN.  | Month Day Year  | April 30, 1969                               |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |   |   |  |
| Ash Co. N.C.   |         | USA                          |  |  |   | Washington  |   |   |  |
| 10. CITY OR TOWN OF DEATH  |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Hagerstown   |         |                              | R # 6 Martin Road  |  |   | Railroad  |   |   | Transportation                               |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?  |   | 13e. STREET AND NUMBER                       |
| Maryland   |         |                              | Washington   |  | Hagerstown  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | R # 6 Martin Road                            |
| 14. FATHER'S NAME  |         |                              | 15. MOTHER'S MAIDEN NAME   |  |   |   |   |   |  |
| First Middle Last  |         |                              | First Middle Last  |  |   |   |   |   |  |
| Lonnie Booker Blevins  |         |                              | Mollie Clark Hoover  |  |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         |                              | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |   |   |   |  |
| No   |         |                              | 705-10-8247  |  | Mrs. Carrie M. Blevins R # 6 Hagerstown, Md.                                    |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |                              |  |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:   |         |                              |  |  |   |   |   |   |  |
| IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia incident to healed</u>   |         |                              |  |  |   |   |   |   | Instant                                      |
| DUE TO, OR AS A CONSEQUENCE OF <u>myocardial infarct</u>   |         |                              |  |  |   |   |   |   |  |
| (b) <u>Coronary atherosclerosis severe with cardiac</u>  |         |                              |  |  |   |   |   |   | Recent                                       |
| DUE TO, OR AS A CONSEQUENCE OF <u>hypertrophy</u>  |         |                              |  |  |   |   |   |   |  |
| (c)  |         |                              |  |  |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         |                              |  |  |   |   |   |   |  |
| 19a. DATE OF OPERATION   |         |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |   | 20. AUTOPSY?  |  |
|  |         |                              |  |  |   |   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |                              | 21b. TIME OF INJURY Month, Day, Year   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |   |   |  |
|  |         |                              | HOUR A.M. P.M.   |  |   |   |   |   |  |
| 21d. INJURY OCCURRED   |         |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |   |   |   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         |                              |  |  |   |   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |                              |  |  |   |   |   |   |  |
| ACTUAL SIGNATURE   |         |                              | CHIEF MEDICAL EXAMINER   |  |   | 22b. DATE SIGNED  |   |   |  |
| EXAMINER'S NAME (Type)   |         |                              | ASSISTANT MEDICAL EXAMINER   |  |   | 5-2-69  |   |   |  |
| Dr. E. W. Ditto, Jr.   |         |                              | DEPUTY MEDICAL EXAMINER  |  |   | Hagerstown, Md.   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)                       |   |  |
| Burial   |         |                              | May 4, 1969  |  | Rest Haven Cemetery   |   | Hagerstown-Washington-Md.   |   |  |
| 24. FUNERAL DIRECTOR   |         |                              | 25d. REC'D BY REGISTRAR  |  |   | 25b. REGISTRAR'S SIGNATURE  |   |   |  |
| Rest Haven Funeral Chapel  |         |                              | Hagerstown, Md.  |  |   | MAY 6 1969  |   |   |  |

06037

UNITED STATES DEPARTMENT OF THE INTERIOR

10

WILLIAM H. HARRIS, Secretary of the Interior

Washington, D.C.

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 10th inst.

and in reply to inform you that the same has been forwarded to the proper authorities.

I am, Sir, very respectfully, your obedient servant.

Very truly yours,

WILLIAM H. HARRIS

Secretary of the Interior

Enclosed for you are two copies of the report of the

Commissioner of the General Land Office, dated the 10th inst.

and containing a full and complete statement of the

proceedings of the Board of Land Commissioners, in relation to

the application of the said Board, for the purchase of the

land in question, and also a copy of the report of the

Board of Land Commissioners, dated the 10th inst.

and containing a full and complete statement of the

proceedings of the Board of Land Commissioners, in relation to

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |  |  |  |  |  |
| 06038 CERTIFICATE OF DEATH 06034   |  |  |  |  |  |   |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b><br>c. LENGTH OF STAY IN lb <b>3 Weeks</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>   |  |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Washington</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RFD-1 Clear Spring</b><br>d. STREET ADDRESS<br>e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>Raymond John Bloyer</b><br>First Middle Last<br>5. SEX <b>Male</b><br>6. COLOR OR RACE <b>White</b><br>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/><br>8. DATE OF BIRTH <b>Oct. 7, 1894</b><br>9. AGE (In years last birthday) <b>74</b> yrs.<br>IF UNDER 1 YEAR Months Days Hours Min.<br>IF UNDER 24 HRS.<br>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b><br>10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b><br>11. BIRTHPLACE (County & State, or foreign country) <b>Wash. Md.</b><br>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b><br>13. FATHER'S NAME <b>David Albert Bloyer</b><br>14. MOTHER'S MAIDEN NAME <b>Mary Grace Rubeck</b><br>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)<br>16. SOCIAL SECURITY NO. <b>214-09-9590</b><br>17. INFORMANT <b>Mrs. Cora Bloyer</b> Address <b>RD-1 Clear Spring</b>  |  |  |  |  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4124 Acute cardiac dilatation &amp; insufficiency.</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerotic cardiovascular disease</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus</b><br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b><br>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)<br>21. I certify that (I) (this hospital) attended the deceased from <b>May 13, 1966</b> , to <b>Apr. 13, 1969</b> , that (I) (we) last saw the deceased alive on <b>April 13, 1969</b> , and that death occurred at <b>11:30 PM</b> from causes and on the date stated above.<br>22a. SIGNATURE <b>William C. Brewer, M.D.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/><br>22b. DATE SIGNED <b>April 14, 1969</b><br>22c. PHYSICIAN'S NAME (Type) <b>William C. Brewer, M.D.</b> 22d. ADDRESS <b>359 E. Baltimore St., Greencastle, Penna</b><br>23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>April 16, 69</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Broadfording</b> 23d. LOCATION (City or Town) (County) (State) <b>Broadfording Wash. Md.</b><br>24. FUNERAL DIRECTOR <b>Thompson Funeral Home</b> ADDRESS <b>Clear Spring, Md.</b> 25a. REC'D BY REGISTRAR <b>APR 22 1969</b> 25b. REGISTRAR'S SIGNATURE <b>OTL...</b> |  |  |  |  |  |   |  |  |  |  |  |



00033

REPORT OF

Washington Maryland

Washington County Hospital 3 weeks

X

Raymond John Blower April 13, 1961

Male White Oct. 7, 1961

U.S.A. 3001

David Albert Blower Harry Grace Huback

214-00-0590 Mrs. Greta Blower 60-1 Blower

new state of Maryland

10

Blower

1961

April 16, 1961

Blower

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |                          |   |       |   |       |   |            |                  |      |       |      |
|--|--|---|--------------------------|---|-------|---|-------|---|------------|------------------|------|-------|------|
| 06039  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201     |                          |   |       | 06035   |       |   |            |                  |      |       |      |
| Item 13 Film 412 5/9/69 kk   |  |   |                          |   |       |   |       |   |            |                  |      |       |      |
| 1. DECEASED-NAME<br>(Type or print)  |  |   | First                    | Middle  | Last  | 2a. DATE OF DEATH   |       | 2b. HOUR  |            |                  |      |       |      |
| DANIEL   |  |   | MILFORD                  | BOWARD  | APRIL |   | Month | 28  | Day        | 1969             | Year | 1 PM  |      |
| 3. SEX   |  | 4. RACE   |                          | 5. DATE OF BIRTH  |       | 6. AGE (In years<br>lost birthday)  |       | IF UNDER 1 YEAR                                 |            | IF UNDER 24 HRS. |      |       |      |
| MALE   |  | WHITE   |                          | 2/7/1891  |       | 78  |       | MONTHS  |            | DAYS             |      | HOURS | MIN. |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |       | 9. COUNTY OF DEATH  |       |   |            |                  |      |       |      |
| PENNSYLVANIA   |  | U.S.A.  |                          |   |       | WASHINGTON  |       | Md.   |            |                  |      |       |      |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |                          | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired)   |       | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |       |   |            |                  |      |       |      |
| BOONSBORO  |  | FAHRNEY KEEDY HOME  |                          | RETIRED TELEGRAPHER   |       | ROAD  |       |   |            |                  |      |       |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) - STATE   |  | 13b. COUNTY   |                          | 13c. CITY OR TOWN   |       | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |       | 13e. STREET AND NUMBER                          |            | 953 View St.     |      |       |      |
| MARYLAND   |  | WASHINGTON  |                          | BOONSBORO   |       |   |       | FAHRNEY/KEEDY/HOME                              |            |                  |      |       |      |
| 14. FATHER'S NAME  |  |   | First                    | Middle  | Last  | 15. MOTHER'S MAIDEN NAME  |       |   | First      | Middle           | Last |       |      |
| JACOB  |  |   | BOWARD                   | MARY  | M.    | GOSSARD   |       |   |            |                  |      |       |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)  |  |   | 16b. SOCIAL SECURITY NO. |   |       | 17. INFORMANT   |       |   | HAGERSTOWN |                  |      |       |      |
| NO   |  |   | 705-10-5235              |   |       | MR. ROSCOE BOWARD   |       |   | MD.        |                  |      |       |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u><br><u>4123</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. (b) <u>arteriosclerotic Heart Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u> |  |   |                          |   |       |   |       | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |            | 2 years          |      | years |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>A few concussions of forehead -</u>   |  |   |                          |   |       |   |       |   |            |                  |      |       |      |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |                          | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |       | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?   |       |   |            |                  |      |       |      |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |       |   |       |   |            |                  |      |       |      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |                          | 21f. LOCATION Street or R.F.D. No.  |       | City or Town  |       | County  |            | State            |      |       |      |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>January, 1959</u> , to <u>April 28, 1959</u> , that (I) (we) last<br>saw the deceased alive on <u>April 28, 1959</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  | 22b. SIGNATURE<br><u>Joseph Seco NDARI</u>                                      |                          | DEGREE  |       | ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/> |       | 22c. DATE SIGNED<br><u>4-29-69</u>              |            |                  |      |       |      |
| 22d. PHYSICIAN'S<br>NAME (Type)  |  | 22e. ADDRESS  |                          | 22f. ADDRESS  |       | 22g. ADDRESS  |       | 22h. ADDRESS                                    |            |                  |      |       |      |
| JOSEPH SECO NDARI  |  | BOONSBORO MD  |                          |   |       |   |       |   |            |                  |      |       |      |
| 23a. BURIAL, CREMATION,<br>REINTERMENT   |  | 23b. DATE   |                          | 23c. NAME OF CEMETERY OR CREMATORY  |       | 23d. LOCATION (City or Town)  |       | (County)  |            | (State)          |      |       |      |
| BURIAL   |  | 4/30/69   |                          | ROSE HILL CEM.  |       | HAGERSTOWN  |       | WASH.   |            | MD.              |      |       |      |
| 24. FUNERAL DIRECTOR   |  | ADDRESS   |                          | 25a. REC'D BY REGISTRAR<br>DATE   |       | 25b. REGISTRAR'S SIGNATURE  |       | 25c. REGISTRAR'S SIGNATURE                      |            |                  |      |       |      |
| W. J. Korman, Hagerstown, Md.  |  |   |                          | MAY 5 1969  |       | Charles Judge   |       |   |            |                  |      |       |      |

05033

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

DATE: 10-1-54 TIME: 10:00 AM BY: J. Edgar Hoover

TO: DIRECTOR, FBI (100-371000) FROM: SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 TM  
45M - 11-69

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |   |  |   |          |
|---|--|--|--|---|--|---|--|---|----------|
| CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |          |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last  |   |  | 2a. DATE OF DEATH<br>Month Day Year   |  |   | 2b. HOUR |
| Margaret Irene Boward   |  |  |  |   |  | April 28 1969   |  |   |          |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  |   | 6. AGE (In years last birthday)                                      |   | 7. YRS.  |
| Female  |  | White  |  | November 12, 1901   |  |   | 67   |   |          |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |   |          |
| Harpers Ferry, W. Va.   |  | USA  |  |   |  | Washington  |  |   |          |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY         |          |
| Hagerstown  |  |  | Washington Co. Hospital  |   |  | Housewife   |  | Own Home                                  |          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER   |   |          |
| Maryland  |  |  | Washington   |   | Hagerstown   |   | 14 Belview Ave.  |   |          |
| 14. FATHER'S NAME First Middle Last   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |   |  |   |  |   |          |
| Luther L Bond   |  |  | Bertha Leigh   |   |  |   |  |   |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address  |   |  |   |          |
| No  |  |  | 214-09-2448 B  |   | Mr. Michael U. Boward 14 Belview Ave., Hagerstown, Md.                                       |   |  |   |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE<br>4109<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE & MYOCARDIAL INFARCTION.<br>DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITUS<br>Approximate interval between onset and death<br>One week<br>Four years |  |  |  |   |  |   |  |   |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |   |  |   |          |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |   |  |   |          |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |          |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/15, 1966, to 4/28, 1969, that (I) <del>xx</del> saw the deceased alive on 4/28, 1969, and that in (my) <del>xx</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>xx</del> (did) view the body after death.   |  |  |  |   |  |   |  |   |          |
| 22b. SIGNATURE<br>Donald E. Martin, M.D.  |  |  |  |   | 22c. DATE SIGNED<br>4/29/69  |   |  |   |          |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |   | 22e. ADDRESS   |   |  |   |          |
| Donald E. Martin, M.D.  |  |  |  |   | 363 S. Cleveland Ave., Hagerstown, Md.   |   |  |   |          |
| 23a. BURIAL, CREMATION, REMOVAL   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)   |  |   |          |
| Burial  |  | May 2, 1969  |  | Rest Haven Cemetery   |  | Hagerstown-Washington-Md.   |  |   |          |
| 24. FUNERAL DIRECTOR<br>Wm. C. Kern<br>Rest Haven Funeral Chapel  |  |  |  | ADDRESS<br>Hagerstown, Md.  |  | 25a. REC'D BY REGISTRAR<br>MAY 2 1969   |  | 25b. REGISTRAR'S SIGNATURE<br>J. J. Judge |          |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |   |  |  |   |  |  |  |
|---|--|--|---|--|--|---|--|--|--|
| 06041   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                    |   |  |  | 06037   |  |  |  |
| CERTIFICATE OF DEATH  |  |  |   |  |  |   |  |  |  |
| 1. DECEASED-NAME (Type or print) <b>GEORGIA LEA BURKE</b>   |  |  | First Middle Last   |  |  | 2a. DATE OF DEATH <b>April 19 Day 69 Year</b>   |  | 2b. HOUR <b>10 30p M</b>                               |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>white</b>   |   | 5. DATE OF BIRTH <b>1-21-23</b>  |  | 6. AGE (In years last birthday) <b>46</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Hagerstown</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>WASHINGTON</b>  |  | Md.  |  |
| 10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address) <b>WESTERN MD. STATE HOSPITAL</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland</b>   |  | 13b. COUNTY <b>Washington</b>  |   | 13c. CITY OR TOWN <b>Hagerstown</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |  | 13e. STREET AND NUMBER <b>318 Linganore Ave.</b>       |  |
| 14. FATHER'S NAME First Middle Last <b>Jack Turner</b>  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last <b>Bertha E. Davis</b> |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service) <b>--</b>  |  |  | 16b. SOCIAL SECURITY NO. <b>219-12-1495</b>                       |  | 17. INFORMANT <b>George M. Burke</b> Address <b>Husband Same</b> |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Posterior Myocardial Infarction</b><br><b>4109</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Occlusion of Right coronary artery</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Carcinoma of the Cervix with metastasis to pelvis &amp; retroperitoneum &amp; adrenal gland. Uterine leiomyosarcoma.</b> |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>within 24 hrs.</b>  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)  |  |   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 2, 1969</b> , to <b>April 19, 1969</b> , that (I) (we) last saw the deceased alive on <b>April 17, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |   |  |  |  |
| 22b. SIGNATURE <b>Fe U. Porciuncula M.D.</b>  |  |  |   | DEGREE <b>MD</b>   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED <b>4/20/69</b>                        |  |
| 22d. PHYSICIAN'S NAME (Type) <b>FE U. PORCIUNCULA</b>   |  |  |   | 22e. ADDRESS <b>Western Maryland State Hospital</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 23b. DATE <b>4/22/69</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Wash Co Md</b>  |  |  |  |
| 24. FUNERAL DIRECTOR <b>Andrew K. Coffman</b>   |  |  |   | ADDRESS <b>Funeral Home Inc</b>  |  | 25a. REC'D BY REGISTRAR <b>APR 23 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>        |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |   |   |  |   |   |  |  |
|--|--|---|---|---|--|---|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |   |   |  |   |   |  |  |
| 06042  |  |   |   |   |  |   |   |  |  |
| CERTIFICATE OF DEATH   |  |   |   |   |  |   |   |  |  |
| 1. DECEASED-NAME<br>(Type or print)<br>JOSEPH WILLIAM CAMPBELL   |  |   | 2a. DATE OF DEATH<br>Month Day Year<br>APRIL 6 1969 |   |  | 2b. HOUR<br>3:40 A.M.   |   |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE  |   | 5. DATE OF BIRTH<br>AUG. 10, 1885   |  | 6. AGE (In years last birthday)<br>83 YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS                                   |  |
| 7a. BIRTHPLACE (State or foreign country)<br>NEW JERSEY  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>WASHINGTON  |   | Md.  |  |
| 10. CITY OR TOWN OF DEATH<br>HAGERSTOWN  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>WASH. CO. HOSP. |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>RETIRED PRINTER  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>PRINTING CO.   |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MD.   |  | 13b. COUNTY<br>WASHINGTON   |   | 13c. CITY OR TOWN<br>HAGERSTOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br>108 GREEN VALLEY DRIVE                 |  |
| 14. FATHER'S NAME<br>First Middle Last<br>FRANCIS CAMPBELL   |  |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last       |   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)   |  | 16b. SOCIAL SECURITY NO.<br>155-09-5088   |   | 17. INFORMANT<br>JOSEPH F. CAMPBELL   |  | Address<br>108 GREEN VALLEY DR.   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u><br>519.2 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Obstructive Pulmonary disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 days<br>years. |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)   |  |   |   |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>Yes |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19                                      |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                    |   | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>64</u> , to <u>Apr. 6</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Apr. 5</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                  |  |   |   |   |  |   |   |  |  |
| 22b. SIGNATURE<br><u>Charles C. Spencer</u>  |  |   |   | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |  | 22c. DATE SIGNED<br><u>Apr 7 1969</u>   |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>CHARLES C. SPENCER, M.D.   |  |   |   | 22e. ADDRESS<br>145 S. PROSPECT ST.   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE<br><u>Apr 9, 1969</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>St Peter's Catholic Cem.</u>   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>New Brunswick Middlesex N. J.</u>           |   |  |  |
| 24. FUNERAL DIRECTOR<br><u>Charles C. Spencer</u>  |  |   |   | ADDRESS<br>ROUZER FUNERAL HOME  |  | 25a. REC'D BY REGISTRAR<br>DATE <u>APR 8 1969</u>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>               |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| 06043   |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 06039  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
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| 1. DECEASED-NAME<br>(Type or print)   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| First Middle Last   |  |  |  |  |  |  |  |  |  | Month Day Year   |  |  |  |  |  |  |  |  |  | M  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Mary Magdelene Clingan  |  |  |  |  |  |  |  |  |  | April 3 1969   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 3. SEX  |  |  |  |  |  |  |  |  |  | 4. RACE  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  |  |  |  |  |  | 6. AGE (In years last birthday)  |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS. HOURS MIN |  |  |  |  |  |  |  |  |  |
| Female  |  |  |  |  |  |  |  |  |  | White  |  |  |  |  |  |  |  |  |  | July 27, 1897  |  |  |  |  |  |  |  |  |  | 71   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  |  |  |  |  |  | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Washington CO. Md.  |  |  |  |  |  |  |  |  |  | USA  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Washington   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Hagerstown  |  |  |  |  |  |  |  |  |  | Washington Co. Hospital  |  |  |  |  |  |  |  |  |  | Housewife  |  |  |  |  |  |  |  |  |  | Own Home   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  |  |  |  |  |  |  |  | 13b. COUNTY  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER      |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Maryland  |  |  |  |  |  |  |  |  |  | Washington   |  |  |  |  |  |  |  |  |  | Hagerstown   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 553 W. Church St.           |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| First Middle Last   |  |  |  |  |  |  |  |  |  | First Middle Last  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| James Edward Gossard  |  |  |  |  |  |  |  |  |  | Mary Susan Ridenour  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service)   |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  |  |  |  |  |  | 17. INFORMANT  |  |  |  |  |  |  |  |  |  | Address  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| No  |  |  |  |  |  |  |  |  |  | 220-09-7017B   |  |  |  |  |  |  |  |  |  | R. J. Clingan  |  |  |  |  |  |  |  |  |  | 553 W. Church St. Hagerstown, Md.  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a)   |  |  |  |  |  |  |  |  |  | Abdominal carcinomatosis   |  |  |  |  |  |  |  |  |  | 19 mo -  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 1830  |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  |  |  |  |  |  |  |  | (b) Adenocarcinoma of ovary  |  |  |  |  |  |  |  |  |  | 21 mo -  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| (c)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Arteriosclerotic Heart Disease  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
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| 22a. I certify that (I) (this hospital) attended the deceased from Aug - 28, 1954, to April 3, 1969, that (I) (we) last saw the deceased alive on April 3, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  |  |  |  |  |  |  | DEGREE   |  |  |  |  |  |  |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Lloyd A. Hoffman  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 4/4/69   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Lloyd A. Hoffman  |  |  |  |  |  |  |  |  |  | 214 N - Potomac St - Hagerstown, Md.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  |  |  |  |  |  |  |  | 23b. DATE  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Burial  |  |  |  |  |  |  |  |  |  | 4/7/69   |  |  |  |  |  |  |  |  |  | Rose Hill Cemetery   |  |  |  |  |  |  |  |  |  | Hagerstown-Washington-Md.  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  |  |  |  |  | ADDRESS  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Wm. C. Horst  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | APR 8 1969   |  |  |  |  |  |  |  |  |  | J. Chmela Judge  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Rest Haven Funeral Chapel   |  |  |  |  |  |  |  |  |  | Hagerstown, Md.  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |   |  |   |  |  |                             |   |  |
|--|--|---|--|---|--|---|--|--|-----------------------------|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |  |   |  |  |                             |   |  |
| CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |                             |   |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>SALLIE LEE CRAMER</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>April 24 1869</b>                   |  |  | 2b. HOUR<br><b>10.30 AM</b> |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>Aug 12 1883</b>  |  | 6. AGE (In years last birthday)<br><b>85</b> YRS.                             |  | IF UNDER 1 YEAR<br>MONTHS DAYS                     |                             | IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Washington</b> Md.                                   |  |  |                             |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Hagerstown</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Wash County Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                          |  |  |                             |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. CITY OR TOWN<br><b>Washington</b>  |  | 13c. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><b>627 No Locust St</b>                             |  |  |                             |   |  |
| 14. FATHER'S NAME First Middle Last<br><b>William Cramer</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>No Record</b>  |  |   |  |  |                             |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br><b>Locate ----- Unable to</b>          |  | 17. INFORMANT Address<br><b>Mrs Rayetta Smith 627 No Locust St</b>  |  |   |  |  |                             |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br><b>4109</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary artery dis.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>Generalized arteriosclerosis</b> |  |   |  |   |  |   |  |  |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2-3 days</b><br><b>years</b><br><b>years</b> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Leg amputation recent. Infection of thumb.</b>  |  |   |  |   |  |   |  |  |                             |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?          |  |  |                             |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |   |  |  |                             |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>Feb 69 Date</b>  |  |   |  |  |                             |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 69</b> , to <b>Date</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>24 Apr 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |                             |   |  |
| 22b. SIGNATURE<br><b>Richard T. Binford</b>  |  | 22c. DATE SIGNED<br><b>25 April 69</b>  |  | 22d. PHYSICIAN'S NAME (Type)<br><b>Richard T. Binford M.D.</b>  |  | 22e. ADDRESS<br><b>1135 Potomac Avenue</b>                                    |  |  |                             |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>4 / 26 / 69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Hagerstown Wash Co Md</b> |  |  |                             |   |  |
| 24. FUNERAL DIRECTOR<br><b>Andrew K. Coffman</b>   |  |   |  | 24b. ADDRESS<br><b>Hagerstown Md</b>  |  | 25a. REC'D BY REGISTRAR<br><b>APR 28 1969</b>                                 |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |                             |   |  |

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in period in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|---|--|--|--|
| 06045 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06041  |  |  |  |  |  |   |  |  |  |
| 1. DECEASED-NAME (Type or Print) First Middle Last<br>Baby Girl Damasiewicz  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year<br>EST. MATED <input type="checkbox"/> 4 15 1969   |  | 2b. HOUR<br>2:20   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>4/15/69  |  | 6. AGE (In years last birthday) <del>XXXX</del> YRS.<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>Month 4 Day 15 Year 19 69  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Washington  |  | p.m.   |  |
| 10. CITY OR TOWN OF DEATH<br>Hagerstown  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>909 Marion St.   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Sec.   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-----   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.   |  |  |  | 13b. COUNTY<br>Wash.   |  | 13c. CITY OR TOWN<br>Hagerstown   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br>909 Marion St.   |  |  |  |  |  |   |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>Walter Michael Damasiewicz  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Sandra Allison Sorenson   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br>No   |  |  |  | 16b. SOCIAL SECURITY NO.<br>----   |  | 17. INFORMANT ADDRESS<br>Mother 909 Marion St., Hagerstown Md.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asphyxia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <u>Aspiration of amniotic fluid</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Seconds</u> |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |  |  |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR MIN<br>2:50 P.M. 4/15/ 19 69  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Aspiration of secretions following delivery  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br>Home |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>909 Marion St., Hagerstown, Wash. Md.  |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>             |  |  |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)   |  | Howard N. Weeks  |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  | 22b. DATE SIGNED<br>4/16/69  |  |
| ADDRESS (Street, city, town, or county)  |  |  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>CREMATION   |  | 23b. DATE<br>4-17-69   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>WASHINGTON COUNTY HOSPITAL   |  | 23d. LOCATION (City or Town) (County) (State)<br>HAGERSTOWN, MARYLAND   |  |  |  |
| 24. FUNERAL DIRECTOR<br>Charles J. Jones   |  |  |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR<br>APR 21 1969  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles J. Jones   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |   |   |  |                                |   |
|--|--|--|--|--|---|---|--|--------------------------------|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |   |  |                                |   |
| CERTIFICATE OF DEATH   |  |  |  |  |   |   |  |                                |   |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |  |   | 2a. DATE OF DEATH   |  |                                | 2b. HOUR  |
| Forrest Leroy Dick   |  |  |  |  |   | Month Day Year<br>April 27, 1969  |  |                                | 8:40 PM   |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS |   |
| Male   |  | White  |  | September 27, 1912   |   | 56 YRS.   |  |                                |   |
| 7a. BIRTHPLACE (State or foreign country)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |                                |   |
| Downsville, Md.  |  |  | U.S.A.   |  |   |   | WASHINGTON Md.   |                                |   |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)         |  |                                | 12b. KIND OF BUSINESS OR INDUSTRY   |
| HAGERSTOWN   |  |  | WESTERN MD. STATE HOSPITAL   |  |   | Sheet Metal Worker  |  |                                | Metal Prod.   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER         |   |
| Maryland   |  |  | Wash.  |  | Sharpsburg  |   |  | Rt. #1                         |   |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |   |  |                                |   |
| First Middle Last<br>Alfred Dick   |  |  | First Middle Last<br>Ella Barret   |  |   |   |  |                                |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address   |   |  |                                |   |
| No.  |  |  |  |  | Mrs. Annabell Dick, Rfd. 1, Sharpsburg, Md.   |   |  |                                |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Brain</u><br><u>1621</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Carcinoma of Right Lung</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |   |   |  |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>8 months</u><br><u>10 months</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |   |   |  |                                |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |                                |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |                                |   |
| 22a. I certify that <u>MD</u> (this hospital) attended the deceased from <u>Feb. 4</u> , 1969, to <u>April 27</u> , 1969, that <u>X</u> (we) last saw the deceased alive on <u>April 27</u> , 1969, and that in <u>MD</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>MD</u> (we) (did) <u>not</u> view the body after death.                                     |  |  |  |  |   |   |  |                                |   |
| 22b. SIGNATURE<br><u>Chong Choon Han</u>   |  |  |  |  | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                   |   | 22c. DATE SIGNED<br>April 27, 1969                                   |                                |   |
| 22d. PHYSICIAN'S NAME (Type)<br>Chong Choon Han  |  |  |  |  | 22e. ADDRESS<br>Western Maryland State Hospital   |   |  |                                |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>4-30-69   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mountain View Cemetery |   | 23d. LOCATION (City or Town) (County) (State)<br>Sharpsburg, Wash. Co., Md.                     |  |                                |   |
| 24. FUNERAL DIRECTOR<br>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.   |  |  |  |  | 25a. REC'D BY REGISTRAR<br>MAY 1 1969   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Jones</u>                   |                                |   |

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COUNTY OF DALLAS, TEXAS

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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06047

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06043

|  |  |                      |                       |  |  |  |  |   |      |  |  |   |  |  |                            |  |  |  |  |
|--|--|----------------------|-----------------------|--|--|--|--|---|------|--|--|---|--|--|----------------------------|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>BESSIE</b>  |  |                      | First <b>VIRGINIA</b> |  |  | Middle <b>EASTERDAY</b>                        |  |   | Last |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/> <b>April 29 1969</b> |  |  | 2b. HOUR <b>10:30 A.M.</b> |  |  |  |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>White</b> |                       | 5. DATE OF BIRTH <b>April 6 1875</b>   |  | 6. AGE (In years last birthday) <b>94</b> YRS. |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  |      | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> |  | 2c. DATE PRONOUNCED DEAD<br>Month <b>April</b> Day <b>29</b> Year <b>1969</b>                                   |  |  | 2d. HOUR <b>10:30 A.M.</b> |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Sharpsburg Md.</b>  |  |                      |                       | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |      |  |  | 9. COUNTY OF DEATH <b>Washington</b>  |  |  |                            |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Hagerstown</b>  |  |                      |                       | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington County Hospital</b> |  |  |  |   |      |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>        |  |  |                            | 12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>   |  |                      |                       | 13b. COUNTY <b>Washington</b>  |  |  |  | 13c. CITY OR TOWN <b>Keedysville</b>  |      |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  | 13e. STREET AND NUMBER <b>Keedysville RFD #1</b> |                            |  |  |  |  |
| 14. FATHER'S NAME<br>First <b>Martin</b> Middle <b>Himes</b> Last <b>Himes</b>   |  |                      |                       | 15. MOTHER'S MAIDEN NAME<br>First <b>Mary</b> Middle <b>Jane</b> Last <b>Mc Coy</b>                            |  |  |  |   |      |  |  |   |  |  |                            |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  |                      |                       | 16b. SOCIAL SECURITY NO. <b>218-38-1754</b>  |  |  |  | 17. INFORMANT ADDRESS <b>Mr. Lester H. Easterday Keedysville Md RFD #1</b>  |      |  |  |   |  |  |                            |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Subacute lymphatic leukemia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>2040</b><br>(b) <b>General arteriosclerosis with coronary insufficiency</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Multiple fracture of pelvis</b> |  |                      |                       |  |  |  |  |   |      |  |  |   |  |  |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year</b><br><b>10 years</b><br><b>20 days</b> |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |                      |                       |  |  |  |  |   |      |  |  |   |  |  |                            |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                      |                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |      |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |  |  |                            |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH  |  |                      |                       | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>11-10- 1969</b><br>P.M. <b>11-10- 1969</b>                |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Fell in home.</b>   |      |  |  |   |  |  |                            |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                      |                       | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Home</b>                    |  |  |  | 21f. LOCATION Street or R.F.D. No. <b>Keedysville,</b> City or Town <b>Washington,</b> County <b>Md.</b> State  |      |  |  |   |  |  |                            |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>               |  |                      |                       |  |  |  |  |   |      |  |  |   |  |  |                            |  |  |  |  |
| ACTUAL SIGNATURE <b>Dr. E. W. Ditto, Jr.</b>   |  |                      |                       | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |      |  |  | 22b. DATE SIGNED <b>April 30, 1969</b>  |  |  |                            |  |  |  |  |
| EXAMINER'S NAME (Type) <b>Dr. E. W. Ditto, Jr.</b>   |  |                      |                       | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |  |  | ADDRESS (Street, city, state) <b>215 W. Washington St., Hagerstown, Md.</b>   |      |  |  |   |  |  |                            |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  |                      |                       | 23b. DATE <b>May 2 1969</b>  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>   |      |  |  | 23d. LOCATION (City or Town) (County) (State) <b>Sharpsburg Maryland</b>  |  |  |                            |  |  |  |  |
| 24. FUNERAL DIRECTOR <b>Albert L. Leaf Williamsport Md.</b>  |  |                      |                       |  |  |  |  | ADDRESS   |      |  |  | 25a. REC'D BY REGISTRAR <b>MAY 5 1969</b>   |  |  |                            | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |  |  |

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FOR SALE  
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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06048

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06044

|  |  |                         |   |   |  |   |  |  |   |  |  |  |  |  |                                   |   |  |  |  |
|--|--|-------------------------|---|---|--|---|--|--|---|--|--|--|--|--|-----------------------------------|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)  |  |                         | First<br><b>HARRY</b>                         |   |  | Middle<br><b>FRANKLIN</b>   |  |  | Last<br><b>EISSNER</b>                  |  |  | 2a. DATE KNOWN OF DEATH<br><input checked="" type="checkbox"/> Month Day Year<br><b>April 14, 1969</b> |  |  | 2b. HOUR<br>M<br>P<br><b>8:40</b> |   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b> |   | 5. DATE OF BIRTH<br><b>June 16, 1891</b>  |  | 6. AGE (In years last birthday)<br><b>77</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS  |   | IF UNDER 24 HRS.<br>HOURS<br>MIN.                                      |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>April 14, 1969</b>                                    |  |  | 2d. HOUR<br>M<br>P<br><b>8:40</b> |   |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Penna</b>  |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Washington</b> |  |  |  |  |  |                                   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Hagerstown</b>   |  |                         |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Walnut Towers Apt. 504</b> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Hauling Business</b> |   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>  |  |  |                                   |   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  |                         |   | 13b. COUNTY<br><b>Washington</b>  |  |   |  | 13c. CITY OR TOWN<br><b>Hagerstown</b>   |   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>        |  |  |                                   | 13e. STREET AND NUMBER<br><b>Walnut Towers Apt. 504</b> |  |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>George W. Eissner</b>   |  |                         |   |   |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Sadie M. Liddick</b>  |  |  |   |  |  |  |  |  |                                   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>   |  |                         |   | 16b. SOCIAL SECURITY NO.<br>(If yes give year or dates of service)<br><b>None</b>                             |  |   |  | 17. INFORMANT<br><b>Earl W. Eissner</b>  |   |  |  | ADDRESS<br><b>Hagerstown, Md 425 Robinwood Drive</b>   |  |  |                                   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gunshot wound of head, self-inflicted</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>sudden</b>       |  |                         |   |   |  |   |  |  |   |  |  |  |  |  |                                   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |                         |   |   |  |   |  |  |   |  |  |  |  |  |                                   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  |  |                                   |   |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |  |                         |   | 21b. TIME OF INJURY Month, Day, Year<br>HOUR-A.M.<br>P.M.<br><b>7:45 P.M. 4/14/69</b>                         |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Shot thru mouth</b>          |   |  |  |  |  |  |                                   |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                         |   | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Residence</b>              |  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>Walnut Towers, Hagerstown, Wash., Md.</b>       |   |  |  |  |  |  |                                   |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |                         |   |   |  |   |  |  |   |  |  |  |  |  |                                   |   |  |  |  |
| ACTUAL SIGNATURE<br><b>Howard N. Weeks</b>   |  |                         |   | M.D.<br><b>Howard N. Weeks</b>  |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |  |  | 22b. DATE SIGNED<br><b>4/15/69</b>   |  |  |                                   |   |  |  |  |
| EXAMINER'S NAME (Type)<br><b>Howard N. Weeks</b>   |  |                         |   | M.D.<br><b>Howard N. Weeks</b>  |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |  |  | 22b. DATE SIGNED<br><b>4/15/69</b>   |  |  |                                   |   |  |  |  |
| 23a. BURIAL, CREMATION, or other disposition (Specify)<br><b>Burial</b>  |  |                         |   | 23b. DATE<br><b>April, 17, 1969</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   |  |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Hagerstown, Md</b> |  |  |  |  |                                   |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Hagerstown, Md. Andrew K. Coffman</b>   |  |                         |   |   |  |   |  | ADDRESS<br><b>Funeral Home Inc.</b>  |   | 25a. REC'D BY REGISTRAR<br>DATE<br><b>APR 21 1969</b>                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>William Judge</b>   |  |  |                                   |   |  |  |  |



22380

CONFIDENTIAL

06049

CERTIFICATE OF DEATH

06045

|  |         |  |                  |   |                                 |   |                                |  |  |
|--|---------|--|------------------|---|---------------------------------|---|--------------------------------|--|--|
| 1. DECEASED-NAME<br>(Type or print)  |         | First  | Middle           | Last  | 2a. DATE OF DEATH               |   | 2b. HOUR                       |  |  |
| Anna   |         | Alice  | Emmert           |   | April 12 1969                   |   | 2:00 P M                       |  |  |
| 3. SEX   | 4. RACE |  | 5. DATE OF BIRTH |   | 6. AGE (In years last birthday) |   | IF UNDER 1 YEAR<br>MONTHS DAYS |  |  |
| Female   | White   |  | August 6, 1890   |   | 78                              |   | IF UNDER 24 HRS.<br>HOURS MIN  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                  | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 | 9. COUNTY OF DEATH  |                                |  |  |
| Martinsburg, W. Va.  |         | USA  |                  |   |                                 | Washington  |                                |  |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |                                 | 12b. KIND OF BUSINESS OR INDUSTRY   |                                |  |  |
| Hagerstown   |         | 770 Weldon Place   |                  | Housewife   |                                 | Own Home  |                                |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         | 13b. COUNTY  |                  | 13c. CITY OR TOWN   |                                 | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |                                | 13e. STREET AND NUMBER                       |  |
| Maryland   |         | Washington   |                  | Hagerstown  |                                 |   |                                | 770 Weldon Place                             |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |                  |   |                                 |   |                                |  |  |
| First Middle Last  |         | First Middle Last  |                  |   |                                 |   |                                |  |  |
| David  |         | Stephey  |                  | Alice Generwa Huntzberry  |                                 |   |                                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |         | 16b. SOCIAL SECURITY NO.   |                  | 17. INFORMANT Address   |                                 |   |                                |  |  |
| No   |         | 214-09-4903D   |                  | Mr. David S. Emmert 834 Monroe Ave. Hagerstown, Md.   |                                 |   |                                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |                  |   |                                 |   |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4109</u> Coronary occlusion   |         |  |                  |   |                                 |   |                                | sudden                                       |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |                  |   |                                 |   |                                |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |         |  |                  |   |                                 |   |                                |  |  |
| (b) <u>Atherosclerotic Heart Disease</u>   |         |  |                  |   |                                 |   |                                | years  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |                  |   |                                 |   |                                |  |  |
| (c)  |         |  |                  |   |                                 |   |                                |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |         |  |                  |   |                                 |   |                                |  |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                                |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |         | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |                                 |   |                                |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                                 |   |                                |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/30/63</u> , 19 <u>63</u> , to <u>4/12</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/12</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |         |  |                  |   |                                 |   |                                |  |  |
| 22b. SIGNATURE   |         |  |                  | DEGREE  |                                 | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                | 22c. DATE SIGNED                             |  |
|  |         |  |                  |   |                                 |   |                                | 4/14/69                                      |  |
| 22d. PHYSICIAN'S NAME (Type)   |         |  |                  | 22e. ADDRESS  |                                 |   |                                |  |  |
| Howard N. Weeks, M. D.   |         |  |                  | 580 Northern Ave., Hagerstown, Md.  |                                 |   |                                |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         | 23b. DATE  |                  | 23c. NAME OF CEMETERY OR CREMATORY  |                                 | 23d. LOCATION (City or Town) (County) (State)   |                                |  |  |
| Burial   |         | 4/16/69  |                  | Rest Haven Cemetery   |                                 | Hagerstown-Washington-Md.   |                                |  |  |
| 24. FUNERAL DIRECTOR   |         |  |                  | ADDRESS   |                                 | 25a. REC'D BY REGISTRAR   |                                | 25b. REGISTRAR'S SIGNATURE                   |  |
| Wm. C. Horst   |         |  |                  | Hagerstown, Md.   |                                 | APR 16 1969   |                                | Charles J. Jagger                            |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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UNITED STATES OF AMERICA

OFFICE OF THE ATTORNEY GENERAL

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## CERTIFICATE OF DEATH

|   |  |  |  |   |   |   |  |  |                                   |  |         |
|---|--|--|--|---|---|---|--|--|-----------------------------------|--|---------|
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First  | Middle  | Last  | 2a. DATE OF DEATH   |  |  | 2b. HOUR                          |  |         |
| Frederick Carlton Ernst Sr.   |  |  |  |   |   | April   |  |  | 9:55 PM                           |  |         |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR  |                                   | IF UNDER 24 HRS.                             |         |
| Male  |  | White  |  | April 17, 1906  |   | 63 YRS.   |  | MONTHS   | DAYS                              | HOURS MIN.                                   |         |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |  |                                   |  |         |
| Wash. Co., Md.  |  | U.S.A.   |  |   |   | Washington Co.  |  | Md.  |                                   |  |         |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |         |
| Clear Spring, Md.   |  |  | Broadfording Road  |   |   | Farmer & Breeder  |  |  | Self Emp.                         |  |         |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET AND NUMBER                       |         |
| Maryland  |  |  |  | Washington  |   | Clear Spring  |  |  |                                   | None   |         |
| 14. FATHER'S NAME   |  |  | First  | Middle  | Last  | 15. MOTHER'S MAIDEN NAME  |  |  | First                             | Middle                                       | Last    |
| Carlton   |  |  | #  |   | Ernst   | Myrtle  |  |  | #                                 |  | Widmyer |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  |  | 16b. SOCIAL SECURITY NO.   |   |   | 17. INFORMANT   |  |  |                                   |  |         |
| No  |  |  | None   |   |   | 215-36-6590 Mrs Ora Ernst, Clear Spring, Md.  |  |  |                                   |  |         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |   |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |         |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Anaplastic Carcinoma of the Carina of the lungs</u>  |  |  |  |   |   |   |  |  |                                   | 4 months                                     |         |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |   |   |  |  |                                   |  |         |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |   |   |   |  |  |                                   |  |         |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |   |   |  |  |                                   |  |         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |   |   |  |  |                                   |  |         |
| Arteriosclerosis Generalized...Coronary Artery Atherosclerosis  |  |  |  |   |   |   |  |  |                                   |  |         |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                                   |  |         |
| 02/21/69  |  | Diagnostic Bronchoscopy  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |                                   |  |         |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |  |                                   |  |         |
|   |  | HOUR A.M. Month Day Year<br>P.M. 19  |  |   |   |   |  |  |                                   |  |         |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION   |   | Street or R.F.D. No.  |  | City or Town   |                                   | County                                       | State   |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |   |   |   |  |  |                                   |  |         |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>06/06/69</u> , 19__, to <u>04/22/69</u> , 19__, that (I) (we) saw the deceased alive on <u>04/22/69</u> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |  |  |                                   |  |         |
| 22b. SIGNATURE  |  |  |  |   |   | 22c. DATE SIGNED  |  |  |                                   |  |         |
| Archie Robert Cohen M.D.  |  |  |  |   |   | 04/23/69  |  |  |                                   |  |         |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |   |   | 22e. ADDRESS  |  |  |                                   |  |         |
| Archie Robert Cohen, M.D.   |  |  |  |   |   | Clear Spring, Maryland 21722  |  |  |                                   |  |         |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town)  |  | (County)   |                                   | (State)                                      |         |
| Burial  |  | 4/25/69  |  | St. Pauls Cemetery  |   | Clear Spring  |  | Wash.  |                                   | Md.  |         |
| 24. FUNERAL DIRECTOR  |  |  |  |   |   | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |                                   |  |         |
| Margaret Rowland Clear Spring, Md.  |  |  |  |   |   | DATE APR 28 1969  |  | Charles Judge  |                                   |  |         |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00020

OFFICE OF THE ATTORNEY GENERAL

Washington, D.C. April 10, 1900

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 4th inst.

in relation to the proposed amendment to the Constitution of the District of Columbia.

The proposed amendment is as follows:

"That the District of Columbia be and it is hereby made a part of the United States."

The proposed amendment is in accordance with the wishes of the people of the District of Columbia.

I am, Sir, very respectfully, your obedient servant.

Very truly yours,

John M. McKim

Attorney General

Washington, D.C.

Enclosed for you are two copies of the proposed amendment.

I am, Sir, very respectfully, your obedient servant.

Very truly yours,

John M. McKim

Attorney General



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06051

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06047

|  |         |                              |  |  |      |   |      |   |   |            |  |  |  |
|--|---------|------------------------------|--|--|------|---|------|---|---|------------|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)  |         |                              | First Middle Last  |  |      | 2a. DATE KNOWN OF DEATH   |      |   |   | 2b. HOUR   |  |  |  |
| ROBERT EUGENE FITCH  |         |                              |  |  |      | Month Day Year  |      |   |   | AP. 8:00 M |  |  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (In years lost birthday)  | IF UNDER 1 YEAR  |      | IF UNDER 24 HRS   |      | 2c. DATE PRONOUNCED DEAD  |   |            |  | 2d. HOUR                                     |  |
| M  | W       | 12-16-1946                   | 22 YRS.  | MONTHS   | DAYS | HOURS   | MIN. | Month Day Year  |   |            |  | 10:30 M                                      |  |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED   |      | NEVER MARRIED   |      | 9. COUNTY OF DEATH  |   |            |  | Md.  |  |
| MARYLAND   |         | U.S.A.                       |  | WIDOWED  |      | DIVORCED  |      | WASHINGTON  |   |            |  |  |  |
| 10. CITY OR TOWN OF DEATH  |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |      |   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |            |  |  |  |
| HAGERSTOWN   |         |                              | WASHINGTON CO. HOSP.   |  |      | CLERK   |      |   | RESTAURANT  |            |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         |                              | 13b. COUNTY  |  |      | 13c. CITY OR TOWN   |      |   | 13d. INSIDE CITY LIMITS?  |            |  | 13e. STREET AND NUMBER                       |  |
| Md.  |         |                              |  |  |      | BALTO.  |      |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |            |  | UNKNOWN                                      |  |
| 14. FATHER'S NAME  |         |                              | 15. MOTHER'S MAIDEN NAME   |  |      |   |      |   |   |            |  |  |  |
| VERNON FITCH   |         |                              | MILDRED O'NEIL   |  |      |   |      |   |   |            |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         |                              | 16b. SOCIAL SECURITY NO.   |  |      | 17. INFORMANT   |      |   | ADDRESS   |            |  |  |  |
| No   |         |                              |  |  |      | Mrs. Mildred Fitch  |      |   | - 624 S. Rappella St.   |            |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |                              |  |  |      |   |      |   |   |            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:   |         |                              |  |  |      |   |      |   |   |            |  | SUDDEN                                       |  |
| IMMEDIATE CAUSE (a)  |         |                              |  |  |      |   |      |   |   |            |  |  |  |
| 953X DUE TO, OR AS A CONSEQUENCE OF  |         |                              |  |  |      |   |      |   |   |            |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |         |                              |  |  |      |   |      |   |   |            |  |  |  |
| (b)  |         |                              |  |  |      |   |      |   |   |            |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |                              |  |  |      |   |      |   |   |            |  |  |  |
| (c)  |         |                              |  |  |      |   |      |   |   |            |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         |                              |  |  |      |   |      |   |   |            |  |  |  |
| 19a. DATE OF OPERATION   |         |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |      |   |      | 20. AUTOPSY?  |   |            |  |  |  |
|  |         |                              |  |  |      |   |      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |   |            |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |                              |  | 21b. TIME OF INJURY Month, Day, Year   |      |   |      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.) |   |            |  |  |  |
|  |         |                              |  | HOUR A.M. P.M. 19  |      |   |      |   |   |            |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         |                              |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |      |   |      | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |   |            |  |  |  |
|  |         |                              |  |  |      |   |      |   |   |            |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                              |  |  |      |   |      |   |   |            |  |  |  |
| ACTUAL SIGNATURE   |         |                              |  | CHIEF MEDICAL EXAMINER   |      |   |      | 22b. DATE SIGNED  |   |            |  |  |  |
| Howard N. Weeks, M.D.  |         |                              |  |  |      |   |      | 4/19/69   |   |            |  |  |  |
| EXAMINER'S NAME (Type)   |         |                              |  | DEPUTY MEDICAL EXAMINER  |      |   |      | ADDRESS (Street, city, town, or county)   |   |            |  |  |  |
| 580 NORTHERN AV  |         |                              |  |  |      |   |      | Washington County   |   |            |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         |                              |  | 23b. DATE  |      |   |      | 23c. NAME OF CEMETERY OR CREMATORY  |   |            |  |  |  |
| BURIAL   |         |                              |  | 4-23-69  |      |   |      | MT. CARMEL CEM.   |   |            |  |  |  |
| 24. FUNERAL DIRECTOR   |         |                              |  | 25a. REC'D BY REGISTRAR  |      |   |      | 25b. REGISTRAR'S SIGNATURE  |   |            |  |  |  |
| John P. Miller   |         |                              |  | DATE 4-24-1969   |      |   |      | John P. Miller  |   |            |  |  |  |

06071

OFFICE OF THE SECRETARY OF DEFENSE

OFFICE OF THE SECRETARY OF DEFENSE

OFFICE OF THE SECRETARY OF DEFENSE



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |                              |   |   |   |   |   |                            |   |  |
|--|--|---|------------------------------|---|---|---|---|---|----------------------------|---|--|
| <div>06052</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>06048</div>   |  |   |                              |   |   |   |   |   |                            |   |  |
| 1. DECEASED-NAME<br>(Type or Print)  |  |   |                              |   | 2a. DATE KNOWN OF ESTI-<br>DEATH MATED  |   |   |   |                            | 2b. HOUR  |  |
| FLOYD EUGENE FITZ  |  |   |                              |   | <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year<br><input checked="" type="checkbox"/> APR. 26 1969 |   |   |   |                            | 2p.M  |  |
| 3. SEX   |  | 4. RACE   |                              | 5. DATE OF BIRTH  |   | 6. AGE (In years<br>last birthday)  |   | IF UNDER 1 YEAR<br>MONTHS DAYS  |                            | IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| Male   |  | White   |                              | Aug. 3, 1933  |   | 35 YRS  |   |   |                            |   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  |   | 7b. CITIZEN OF WHAT COUNTRY? |   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. COUNTY OF DEATH         |   |  |
| W. Va.   |  |   | U.S.A.                       |   |   |   |   |   | Washington                 |   |  |
| 10. CITY OR TOWN OF DEATH  |  |   |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |   |   |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)      |                            | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |
| Hagerstown   |  |   |                              | Washington County Hospital  |   |   |   | Electrician   |                            | Electric Co.  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |  |   |                              | 13b. COUNTY   |   | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                            | 13e. STREET AND NUMBER  |  |
| W. Va.   |  |   |                              | Berkeley  |   | Martinsburg   |   |   |                            | Route 2 (Lights Addition)   |  |
| 14. FATHER'S NAME  |  |   |                              |   | 15. MOTHER'S MAIDEN NAME  |   |   |   |                            |   |  |
| George Buxton Fitz   |  |   |                              |   | Mary Lee Hoover   |   |   |   |                            |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |  |   |                              | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS   |   |   |                            |   |  |
| No   |  |   |                              | 233-48-6981   |   | Mrs. Mary Lee Fitz-Rt. 2, Martinsburg, W. Va.   |   |   |                            |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ACUTE SUBDURAL HEMATOMA<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) COMPOUND FRACT. OF BOTH WRISTS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |                              |   |   |   |   |   |                            | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>18 HOURS                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |                              |   |   |   |   |   |                            |   |  |
| 19a. DATE OF OPERATION   |  |   |                              |   | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?  |   |   |   |                            | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING<br>CAUSE OF DEATH  |  |   |                              |   | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |                            |   |  |
|  |  |   |                              |   | 8:40PM 4-25 1969  |   | IN COLLISION WITH TRUCK   |   |                            |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE<br>AT WORK <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.) |                              |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |   |                            |   |  |
|  |  | U. S. 11 (4 MI. N.)   |                              |   | MARTINSBURG, BERKELEY COUNTY, W. VA.  |   |   |   |                            |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |                              |   |   |   |   |   |                            |   |  |
| ACTUAL SIGNATURE   |  |   |                              |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |   |   |                            | 22b. DATE SIGNED  |  |
| EXAMINER'S NAME (Type)   |  |   |                              |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |   |   |                            | 4-27-69   |  |
| DR. E. W. DITTO, JR.   |  |   |                              |   | ADDRESS (Street, city, town, or county)   |   |   |   |                            | Hagerstown, Maryland  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  | 23b. DATE   |                              | 23c. NAME OF CEMETERY OR CREMATORY  |   |   | 23d. LOCATION (City or Town) (County) (State)                                   |   |                            |   |  |
| Burial   |  | 4-30-1969   |                              | Green Hill Cemetery   |   |   | Martinsburg Berkeley W. Va.   |   |                            |   |  |
| 24. FUNERAL DIRECTOR   |  |   |                              |   |   | 25a. REC'D BY REGISTRAR   |   |   | 25b. REGISTRAR'S SIGNATURE |   |  |
| Brown Funeral Home, Inc. Martinsburg, W. Va.   |  |   |                              |   |   | APR 29 1969   |   |   | J. C. Jones                |   |  |

00032

20 100 29

18 HOURS

ACUTE SUBDURAL HEMATOMA  
COMPOUND FRACT. OF BOTH WRISTS

IN COLLISION WITH TRUCK

X U. S. 11 (4 M. I.) MARTINSBURG, BERKELEY COUNTY, W. VA.

X

X

1-27-62

X

DR. E. W. DITTO, JR.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |                              |   |  |  |  |  |
|--|--|--|--|--|------------------------------|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |                              |   |  |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |                              |   |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |  |                              | 2a. DATE OF DEATH   |  | 2b. HOUR   |  |  |
| Nellie Mae Follin  |  |  |  |  |                              | 4 Month 7 Day 69 Year   |  | 1:28 PM  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |                              | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR  |  |  |
| female   |  | white  |  | 10-16-1884   |                              | 84 YRS.   |  | MONTHS DAYS HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. COUNTY OF DEATH  |  |  |  |  |
| Va.  |  | USA  |  |  |                              | Washington  |  | Md.  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                              | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |
| Hagerstown   |  |  | Martin Manor Nursing Home  |  |                              | Housewife   |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN            |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                       |  |
| Md.  |  |  | Wash.  |  | Hagerstown                   |   |  |  | 400 W. Howard St.                            |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |                              |   |  |  |  |  |
| First Middle Last  |  |  | First Middle Last  |  |                              |   |  |  |  |  |
| William F. Tribby  |  |  | Emma J. Mock   |  |                              |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT                |   |  |  |  |  |
| no   |  |  | 214-46-6159  |  | James Follin Hagerstown, Md. |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |                              |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |                              |   |  |  |  |  |
| IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>  |  |  |  |  |                              |   |  |  | 4 day  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis &amp; Senility</u>  |  |  |  |  |                              |   |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |  |  |  |                              |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |                              |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |                              | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
|  |  |  |  |  |                              |   |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                              |   |  |  |  |  |
|  |  | HOUR A.M. Month Day Year   |  |  |                              |   |  |  |  |  |
|  |  | P.M. 19  |  |  |                              |   |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION  |                              | Street or R.F.D. No.  |  | City or Town County State  |  |  |
|  |  |  |  |  |                              |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/13</u> , 19 <u>67</u> , to <u>4/14/69</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>11/14/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |                              |   |  |  |  |  |
| 22b. SIGNATURE   |  | 22c. DATE SIGNED   |  |  |                              |   |  |  |  |  |
| Robert H Campbell  |  | 4/18/69  |  |  |                              |   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS   |  |  |                              |   |  |  |  |  |
| ROBERT CAMPBELL  |  | Hagerstown Md.   |  |  |                              |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                              | 23d. LOCATION (City or Town) (County) (State)   |  |  |  |  |
| Burial   |  | 4-9-69   |  | Rest Haven Cemetery  |                              | Hagerstown, Md.   |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  | ADDRESS  |                              | 25a. REG. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |
| Minnich Funeral Home   |  |  |  | Hagerstown, Md.  |                              | APR 10 1969   |  | [Signature]  |  |  |



UNITED STATES DEPARTMENT OF THE INTERIOR

10000

REPORT OF THE UNITED STATES GEOLOGICAL SURVEY  
ON THE GEOLOGY OF THE  
SOUTHERN PART OF THE  
STATE OF TEXAS  
BY  
JOHN W. COVILLE  
AND  
JOHN W. COVILLE

10000

UNITED STATES GEOLOGICAL SURVEY  
WASHINGTON, D. C.

10000

REPORT OF THE UNITED STATES GEOLOGICAL SURVEY  
ON THE GEOLOGY OF THE  
SOUTHERN PART OF THE  
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JOHN W. COVILLE  
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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |         |   |  |   |  |  |   |                             |  |
|--|---------|---|--|---|--|--|---|-----------------------------|--|
| <div>06054</div> <div>06050</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div>   |         |   |  |   |  |  |   |                             |  |
| 1. DECEASED-NAME<br>(Type or Print)  |         |   | First Middle Last  |   |  | 2a. DATE KNOWN OF DEATH  |   |                             | 2b. HOUR   |
| Clyde Alton Frain  |         |   |  |   |  | <input checked="" type="checkbox"/> Month Day Year<br><input type="checkbox"/> 4 25 1969     |   |                             | 5 02 PM  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN  |   | 2c. DATE PRONOUNCED DEAD    | 2d. HOUR   |
| male   | white   | 10-9-1926   | 42 YRS.  |   |  |  |   | Month Day Year<br>4 25 1969 | 5 02 PM  |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |   |                             | Md.  |
| Pa.  |         | USA   |  |   |  | Washington   |   |                             |  |
| 10. CITY OR TOWN OF DEATH  |         |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |   |                             | 12b. KIND OF BUSINESS OR INDUSTRY                              |
| Hagerstown   |         |   | Washington Co. Hospital  |   |  | mechanic   |   |                             |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         |   | 13b. COUNTY  |   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 13e. STREET AND NUMBER  |                             |  |
| Pa.  |         |   | Huntingdon   |   | Hustontown   |  | Star Rute   |                             |  |
| 14. FATHER'S NAME First Middle Last  |         |   | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |   |  |  |   |                             |  |
| Edward Frain   |         |   | Mary Harshberger   |   |  |  |   |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         |   | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS  |  |   |                             |  |
| Yes <input checked="" type="checkbox"/> WW II  |         |   |  |   | Mrs. Althea Frain, Hustontown, Pa.   |  |   |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Subdural Hematoma; Midbrain</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hemorrhage - Due to Massive +</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Severe Chronic Cerebral Trauma</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |         |   |  |   |  |  |   |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>21 hrs.</u> |
| 19a. DATE OF OPERATION   |         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |   |  | 20. AUTOPSY?   |   |                             |  |
| 4-24-69  |         |   | Massive Subdural Hematoma  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |   |                             |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |   | 21b. TIME OF INJURY Month, Day, Year<br>HOUR:MIN<br>8:25 PM 4/24/69          |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Fell off Army tank - Struck Head. |  |   |                             |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br>Letterkenny |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>Letterkenny Ordn. Depot - Penn.   |  |  |   |                             |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                      |         |   |  |   |  |  |   |                             |  |
| ACTUAL SIGNATURE<br><u>Edward W. Ditto</u>   |         |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                              |   |  | 22b. DATE SIGNED<br>4-25-69  |   |                             |  |
| EXAMINER'S NAME (Type)<br>EDWARD W. DITTO, III, M.D.   |         |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                          |   |  | 217 W. WASHINGTON ST.  |   |                             |  |
|  |         |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                  |   |  | HAGERSTOWN, MARYLAND   |   |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>burial  |         |   | 23b. DATE<br>4-28-69   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Methodist Cemetary   |  | 23d. LOCATION (City or Town) (County) (State)<br>Huntingdon Co. Pa. |                             |  |
| 24. FUNERAL DIRECTOR ADDRESS<br>Minnich Funeral Home Hagerstown, Md.   |         |   |  |   | 25a. REC'D BY REGISTRAR<br>DATE APR 28 1969  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                         |                             |  |

2206

start not 12 obv 13

10-1050-1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 13-taken from birth

MARYLAND STATE DEPARTMENT OF HEALTH

certif

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06055

CERTIFICATE OF DEATH

06051

|  |                              |  |  |  |                                     |  |   |
|--|------------------------------|--|--|--|-------------------------------------|--|---|
| 1. DECEASED-NAME<br>(Type or print)  |                              | First  | Middle   | Last   | 2a. DATE OF DEATH<br>Month Day Year |  | 2b. HOUR  |
|  |                              |  |  | #1 Fuss  | April 28 1969                       |  | 2:40pm  |
| 3. SEX   | 4. RACE                      |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)     |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |
| Female   | White                        |  | April 27, 1969   |  | YRS.                                |  | IF UNDER 24 HRS.<br>HOURS MIN   |
| 7a. BIRTHPLACE (State or foreign country)  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH                  |  | Md.   |
| Maryland   | U.S.A.                       |  |  |  | Washington County                   |  |   |
| 10. CITY OR TOWN OF DEATH  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |                                     | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| Hagerstown   |                              | Washington County  |  |  |                                     |  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN  |                                     | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| Maryland   |                              | Washington   |  | Hagerstown   |                                     | 13e. STREET AND NUMBER   |   |
|  |                              |  |  |  |                                     | 14 W. Lincoln Avenue   |   |
| 14. FATHER'S NAME  |                              | First Middle Last  |  | 15. MOTHER'S MAIDEN NAME   |                                     | First Middle Last  |   |
| James F. Fuss  |                              |  |  | Charlene Grayce  |                                     |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |                              | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |                                     | Address  |   |
|  |                              |  |  |  |                                     |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary insufficiency</u><br>7769 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>pulmonary atelectasis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                              |  |  |  |                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>hrs</u><br><u>hrs</u><br><u>15 min</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Premature delivery &amp; anoxia due to cord compression</u>  |                              |  |  |  |                                     |  |   |
| 19a. DATE OF OPERATION   |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                     | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>              |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |                              | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |                                     |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |                                     |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 27</u> , 19 <u>69</u> , to <u>April 28</u> , 19 <u>69</u> , that (I) (we) lost the deceased alive on <u>April 28</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.         |                              |  |  |  |                                     |  |   |
| 22b. SIGNATURE<br><u>Harold R. Tritch Jr. M.D.</u>   |                              |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                     | 22c. DATE SIGNED<br><u>4/29/69</u>   |   |
| 22d. PHYSICIAN'S NAME (Type)<br><u>HAROLD R. TRITCH JR.</u>  |                              |  |  | 22e. ADDRESS<br><u>HAGERSTOWN, Md. 21740</u>   |                                     |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                                     | 23d. LOCATION (City or Town) (County) (State)  |   |
| CREMATION  |                              | 4-30-69  |  | WASHINGTON COUNTY HOSPITAL   |                                     | HAGERSTOWN, MARYLAND   |   |
| 24. FUNERAL DIRECTOR<br><u>John Schoffer, adm. Wash. Co. Hosp.</u>   |                              |  |  | 25a. REC'D BY REGISTRAR<br><u>MAY 2 1969</u>   |                                     | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |   |

James F. Foss  
Hagerston  
Washington County  
U.S.A.  
Washington County  
April 21, 1942  
April 22, 1942

X

April 21, 1942



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |   |       |  |   |  |  |                                 |  |
|---|--|---|-------|--|---|--|--|---------------------------------|--|
| 06056   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |       |  |   | 06052  |  |                                 |  |
| CERTIFICATE OF DEATH  |  |   |       |  |   |  |  |                                 |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |   | First | Middle   | Lost  | 2a. DATE OF DEATH<br>Month Day Year  |  |                                 |  |
| WILLIAM PRESTON GEARHART SR.  |  |   |       |  |   | APRIL 13 1969  |  |                                 |  |
| 3. SEX  |  | 4. RACE   |       | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)  |  |                                 |  |
| MALE  |  | WHITE   |       | 12/23/1904   |   | 84 YRS.  |  |                                 |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |                                 |  |
| MARYLAND  |  | U.S.A.  |       |  |   | WASHINGTON   |  |                                 |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital given place of death) |       | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                                 |  |
| HAGERSTOWN  |  | WASHINGTON CO. HOSPITAL   |       | RETIRED  |   | STORAGE OPERATOR MFG. CO   |  |                                 |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY   |       | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                 |  |
| MARYLAND  |  | WASHINGTON  |       | HAGERSTOWN   |   | RT. #5   |  |                                 |  |
| 14. FATHER'S NAME   |  |   | First | Middle   | Lost  | 15. MOTHER'S MAIDEN NAME   |  |                                 |  |
| CHARLES D. GEARHART   |  |   |       |  |   | ADA HYDE   |  |                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)  |  | 16b. SOCIAL SECURITY NO.  |       | 17. INFORMANT  |   | Address  |  |                                 |  |
| NO  |  | 220-16-3729   |       | MRS. MARY B. GEARHART HAGERSTOWN   |   | RT #5 MD.  |  |                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |       |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                                 |  |
| PART 1. DEATH WAS CAUSED BY:  |  |   |       |  |   |  |  |                                 |  |
| IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>   |  |   |       |  |   | Instant  |  |                                 |  |
| 4109 DUE TO, OR AS A CONSEQUENCE OF   |  |   |       |  |   |  |  |                                 |  |
| (b) <u>Arteriosclerotic Cardiovascular Disease</u>  |  |   |       |  |   | 5 yrs.   |  |                                 |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |       |  |   |  |  |                                 |  |
| (c)   |  |   |       |  |   |  |  |                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |       |  |   |  |  |                                 |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |       |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19                    |       |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |                                 |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)  |       |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                      |  |  |                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-11-1964, to 4-13-1969, that (I) (we) last saw the deceased alive on 4-3-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |       |  |   |  |  |                                 |  |
| 22b. SIGNATURE<br>Charles F. Hess M.D.  |  |   |       | 22c. DATE SIGNED<br>4-15-69  |   | 22d. PHYSICIAN'S NAME (Type)<br>CHARLES F. HESS M.D.   |  | 22e. ADDRESS<br>Smithsburg, Md. |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE   |       | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)  |  |                                 |  |
| BURIAL  |  | 4/16/69   |       | ROSE HILL CEM.   |   | HAGERSTOWN WASH. MD.   |  |                                 |  |
| 24. FUNERAL DIRECTOR<br>W. F. Norman, Hagerstown, Md.   |  |   |       | 25a. REC'D BY REGISTRAR<br>DATE APR 18 1969  |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge  |  |                                 |  |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06057

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06053

|  |  |                         |                        |   |  |  |  |   |                          |   |  |   |  |  |                            |  |  |  |  |
|--|--|-------------------------|------------------------|---|--|--|--|---|--------------------------|---|--|---|--|--|----------------------------|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)  |  |                         | First<br><b>Marion</b> |   |  | Middle<br><b>Arthur</b>  |  |   | Last<br><b>Gettridge</b> |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> Month Day Year<br><b>April 12 1969</b> |  |  | 2b. HOUR<br><b>8:45 PM</b> |  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b> |                        | 5. DATE OF BIRTH<br><b>Jan. 21, 1899</b>  |  | 6. AGE (In years last birthday)<br><b>70</b> YRS.              |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |                          | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>April 12 1969</b>  |  |  | 2d. HOUR<br><b>9:00 PM</b> |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  |                         |                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>           |                          |   |  | 9. COUNTY OF DEATH<br><b>Washington</b>   |  |  |                            |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Hagerstown</b>   |  |                         |                        | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Washington</b> |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>foreman road const.</b>   |                          |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>  |  |  |                            |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  |                         |                        | 13b. COUNTY<br><b>Washington</b>  |  |  |  | 13c. CITY OR TOWN<br><b>Sharpsburg</b>  |                          |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                 |  | 13e. STREET AND NUMBER<br><b>121 E. Chapline St.</b>                           |                            |  |  |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>James Franklin Gettridge</b>  |  |                         |                        | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Margaret Whitlock</b>                         |  |  |  |   |                          |   |  |   |  |  |                            |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>   |  |                         |                        | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br><b>214-14-6933</b>           |  |  |  | 17. INFORMANT<br><b>Mrs. Clara Gettridge</b>  |                          |   |  | ADDRESS<br><b>Sharpsburg, Md.</b>   |  |  |                            |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Diabetic Acidosis and severe generalized</b><br><b>2500</b> DUE TO, OR AS A CONSEQUENCE OF <b>(Atherosclerosis.)</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____                 |  |                         |                        |   |  |  |  |   |                          |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Hours</b><br><b>(years)</b> |                            |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Fractured right hip.</b>  |  |                         |                        |   |  |  |  |   |                          |   |  |   |  |  |                            |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                         |                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |                          |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |  |  |                            |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/><br>CAUSE OF DEATH   |  |                         |                        | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br><b>2:00 PM 3/13 1969</b>                     |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Patient fell getting on bedside commode</b>                                     |                          |   |  |   |  |  |                            |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                         |                        | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Home</b>       |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town State<br><b>121 E. Chapline St., Sharpsburg, Md.</b>  |                          |   |  |   |  |  |                            |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                         |                        |   |  |  |  |   |                          |   |  |   |  |  |                            |  |  |  |  |
| ACTUAL SIGNATURE<br><b>Howard N. Weeks</b>   |  |                         |                        | EXAMINER'S NAME (Type)<br><b>Howard N. Weeks, M. D.</b>   |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |                          |   |  | 22b. DATE SIGNED<br><b>4/14/69</b>  |  |  |                            |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |                         |                        | 23b. DATE<br><b>April 15, 1969</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. View Cemetery</b> |  |   |                          | 23d. LOCATION (City or Town) (County) (State)<br><b>Sharpsburg, Washington, Md.</b> |  |   |  |  |                            |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Albert L. leaf</b>  |  |                         |                        |   |  |  |  | ADDRESS<br><b>Williamsport, Maryland</b>  |                          |   |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>APR 17 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                             |                            |  |  |  |  |

06057

RESEARCH INSTITUTE, UNIVERSITY OF MICHIGAN

1955

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APR 15 1955

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 7/68

| MARTLAND STATE DEPARTMENT OF HEALTH  |  |                              |  |  |                                    |   |  |  |                        |  |      |
|--|--|------------------------------|--|--|------------------------------------|---|--|--|------------------------|--|------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                              |  |  |                                    |   |  |  |                        |  |      |
| 060558   |  |                              |  |  |                                    |   |  |  |                        |  |      |
| CERTIFICATE OF DEATH   |  |                              |  |  |                                    |   |  |  |                        |  |      |
| 1. DECEASED-NAME<br>(Type or print)  |  |                              | First  | Middle   | Lost                               | 2a. DATE OF DEATH   |  |  | 2b. HOUR               |  |      |
| Kenneth Lee Hart   |  |                              |  |  |                                    | April 4 1969  |  |  | 1:30 AM                |  |      |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH   |                                    | 6. AGE (In years lost birthday)   |  | IF UNDER 1 YEAR  |                        |  |      |
| Male   |  | White                        |  | Dec. 22, 1920  |                                    | 48 YRS.   |  | MONTHS DAYS HOURS MIN  |                        |  |      |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. COUNTY OF DEATH  |  |  |                        |  |      |
| Big Pool, Md.  |  | U.S.A.                       |  |  |                                    | Washington Md.  |  |  |                        |  |      |
| 10. CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |                        |  |      |
| Hagerstown   |  |                              | Washington Co. Hosp.   |  |                                    | Truck driver  |  | Road Contr.  |                        |  |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN                  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER |  |      |
| Maryland   |  |                              | Washington   |  | Big Spring                         |   |  |  | None                   |  |      |
| 14. FATHER'S NAME  |  |                              | First  | Middle   | Lost                               | 15. MOTHER'S MAIDEN NAME  |  |  | First                  | Middle                                       | Lost |
| Arthur Grant Hart  |  |                              |  |  |                                    | Mary Ann Beard  |  |  |                        |  |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |                              | 16b. SOCIAL SECURITY NO.   |  |                                    | 17. INFORMANT   |  |  |                        |  |      |
| No   |  |                              | None   |  |                                    | 217-32-5411 James Hart Big Spring, Md.  |  |  |                        |  |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |                              |  |  |                                    |   |  |  |                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |      |
| PART I. DEATH WAS CAUSED BY:   |  |                              |  |  |                                    |   |  |  |                        | one hour                                     |      |
| IMMEDIATE CAUSE (a) Myocardial Infarction, due to coronary artery occlusion  |  |                              |  |  |                                    |   |  |  |                        |  |      |
| DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease  |  |                              |  |  |                                    |   |  |  |                        | two years                                    |      |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |                              |  |  |                                    |   |  |  |                        |  |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |                              |  |  |                                    |   |  |  |                        |  |      |
| None   |  |                              |  |  |                                    |   |  |  |                        |  |      |
| 19a. DATE OF OPERATION   |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |                                    | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                        |  |      |
| = = = =  |  |                              |  |  |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  |  |                        |  |      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |                              | 21b. TIME OF INJURY  |  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |  |  |                        |  |      |
|  |  |                              | HOUR A.M. Month Day Year P.M. 19   |  |                                    |   |  |  |                        |  |      |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |  |  |                        |  |      |
|  |  |                              |  |  |                                    |   |  |  |                        |  |      |
| 22a. I certify that (I) (this hospital) attended the deceased from 03/15/67, 19, to 04/04/69, 19, that (I) (we) saw the deceased alive on April 04, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                              |  |  |                                    |   |  |  |                        |  |      |
| 22b. SIGNATURE   |  |                              | 22c. DATE SIGNED   |  |                                    | 22d. PHYSICIAN'S NAME (Type)  |  |  |                        |  |      |
| Archie Robert Cohen  |  |                              | 04/04/69   |  |                                    | Archie Robert Cohen, M.D.   |  |  |                        |  |      |
| 22e. ADDRESS   |  |                              | 22f. ADDRESS   |  |                                    |   |  |  |                        |  |      |
| Clear Spring, Maryland 21722   |  |                              | Clear Spring, Maryland 21722   |  |                                    |   |  |  |                        |  |      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |   |  | 23d. LOCATION (City or Town) (County) (State)                        |                        |  |      |
| Burial   |  |                              | 4/7/69   |  | St. Pauls Cemetery                 |   |  | Clear Spring Wash. Md.   |                        |  |      |
| 24. FUNERAL DIRECTOR   |  |                              | 25a. REC'D BY REGISTRAR  |  |                                    | 25b. REGISTRAR'S SIGNATURE  |  |  |                        |  |      |
| Margaret Rawland   |  |                              | APR 8 1969   |  |                                    | Charles Judge   |  |  |                        |  |      |



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RECEIVED

TO : [illegible] FROM : [illegible]

SUBJECT : [illegible]

DATE : [illegible]

REFERENCE : [illegible]

REMARKS : [illegible]

APPROVED : [illegible]

SIGNED : [illegible]

POSTED : [illegible]

FILED : [illegible]

INDEXED : [illegible]

SEARCHED : [illegible]

SERIALIZED : [illegible]

RECEIVED : [illegible]

DATE : [illegible]

TIME : [illegible]

BY : [illegible]

FOR : [illegible]

AT : [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |                   |  |   |  |  |   |   |
|--|--|--|-------------------|--|---|--|--|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |                   |  |   |  |  |   |   |
| 06059 CERTIFICATE OF DEATH 06055   |  |  |                   |  |   |  |  |   |   |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last |  |   | 2a. DATE OF DEATH  |  |   | 2b. HOUR  |
| Anthony Benjamin Haslacker   |  |  |                   |  |   | April 9 1969   |  |   | 11:10 P   |
| 3. SEX   |  | 4. RACE  |                   | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                                     |   |
| Male   |  | White  |                   | 6/27/78  |   | 90 YRS.  |  |   |   |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |   |   |
| West Virginia  |  | USA  |                   |  |   | WASHINGTON Md.   |  |   |   |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |   |
| HAGERSTOWN   |  | WESTERN MD. STATE HOSPITAL   |                   | Ret. Store Prop.   |   | Grocery  |  |   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission). STATE   |  | 13b. COUNTY  |                   | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER  |   |
| Maryland   |  | Washington   |                   | Hagerstown   |   |  |  | 1079 View Street  |   |
| 14. FATHER'S NAME  |  |  | First Middle Last |  |   | 15. MOTHER'S MAIDEN NAME   |  |   | First Middle Last   |
| John Haslacker   |  |  |                   |  |   | Elizabeth Hesse  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown  |  | (If yes give war or dates of service)  |                   | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address  |  |   |   |
| No   |  |  |                   | 214-05-6938  |   | Mrs. Robert L. Hackett 130 Donnybrook Dr. Hagerstown, Md.                                    |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br><u>4124</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |                   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>6 months</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Gangrene on right foot</u>  |  |  |                   |  |   |  |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)  |   |  |  |   |   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |  |   |   |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Sept. 17, 1968</u> , to <u>April 9, 1969</u> , that (I) (we) saw the deceased alive on <u>April 9, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.  |  |  |                   |  |   |  |  |   |   |
| 22b. SIGNATURE   |  | 22c. DATE SIGNED   |                   | 22d. PHYSICIAN'S NAME (Type)   |   | 22e. ADDRESS   |  | 22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   |
| <u>Chong Choon Han</u>   |  | <u>4/10/69</u>   |                   | Chong Choon Han, M.D.  |   | Western Maryland State Hospital<br>1500 Pennsylvania Ave., Hagerstown, Md.                   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |                   | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)  |  |   |   |
| <u>Burial</u>  |  | <u>4/12/69</u>   |                   | <u>Hillcrest Burial Park,</u>  |   | <u>Cumberland, Allegany Md.</u>  |  |   |   |
| 24. FUNERAL DIRECTOR ADDRESS   |  |  |                   | 25a. REC'D BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |  |   |   |
| H. Wayne George Cumberland, Maryland   |  |  |                   | APR 14 1969  |   | <u>William J. Suddell</u>  |  |   |   |

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|   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |    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    |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     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185 | 186 | 187 | 188 | 189 | 190 | 191 | 192 | 193 | 194 | 195 | 196 | 197 | 198 | 199 | 200 | 201 | 202 | 203 | 204 | 205 | 206 | 207 | 208 | 209 | 210 | 211 | 212 | 213 | 214 | 215 | 216 | 217 | 218 | 219 | 220 | 221 | 222 | 223 | 224 | 225 | 226 | 227 | 228 | 229 | 230 | 231 | 232 | 233 | 234 | 235 | 236 | 237 | 238 | 239 | 240 | 241 | 242 | 243 | 244 | 245 | 246 | 247 | 248 | 249 | 250 | 251 | 252 | 253 | 254 | 255 | 256 | 257 | 258 | 259 | 260 | 261 | 262 | 263 | 264 | 265 | 266 | 267 | 268 | 269 | 270 | 271 | 272 | 273 | 274 | 275 | 276 | 277 | 278 | 279 | 280 | 281 | 282 | 283 | 284 | 285 | 286 | 287 | 288 | 289 | 290 | 291 | 292 | 293 | 294 | 295 | 296 | 297 | 298 | 299 | 300 | 301 | 302 | 303 | 304 | 305 | 306 | 307 | 308 | 309 | 310 | 311 | 312 | 313 | 314 | 315 | 316 | 317 | 318 | 319 | 320 | 321 | 322 | 323 | 324 | 325 | 326 | 327 | 328 | 329 | 330 | 331 | 332 | 333 | 334 | 335 | 336 | 337 | 338 | 339 | 340 | 341 | 342 | 343 | 344 | 345 | 346 | 347 | 348 | 349 | 350 | 351 | 352 | 353 | 354 | 355 | 356 | 357 | 358 | 359 | 360 | 361 | 362 | 363 | 364 | 365 | 366 | 367 | 368 | 369 | 370 | 371 | 372 | 373 | 374 | 375 | 376 | 377 | 378 | 379 | 380 | 381 | 382 | 383 | 384 | 385 | 386 | 387 | 388 | 389 | 390 | 391 | 392 | 393 | 394 | 395 | 396 | 397 | 398 | 399 | 400 | 401 | 402 | 403 | 404 | 405 | 406 | 407 | 408 | 409 | 410 | 411 | 412 | 413 | 414 | 415 | 416 | 417 | 418 | 419 | 420 | 421 | 422 | 423 | 424 | 425 | 426 | 427 | 428 | 429 | 430 | 431 | 432 | 433 | 434 | 435 | 436 | 437 | 438 | 439 | 440 | 441 | 442 | 443 | 444 | 445 | 446 | 447 | 448 | 449 | 450 | 451 | 452 | 453 | 454 | 455 | 456 | 457 | 458 | 459 | 460 | 461 | 462 | 463 | 464 | 465 | 466 | 467 | 468 | 469 | 470 | 471 | 472 | 473 | 474 | 475 | 476 | 477 | 478 | 479 | 480 | 481 | 482 | 483 | 484 | 485 | 486 | 487 | 488 | 489 | 490 | 491 | 492 | 493 | 494 | 495 | 496 | 497 | 498 | 499 | 500 | 501 | 502 | 503 | 504 | 505 | 506 | 507 | 508 | 509 | 510 | 511 | 512 | 513 | 514 | 515 | 516 | 517 | 518 | 519 | 520 | 521 | 522 | 523 | 524 | 525 | 526 | 527 | 528 | 529 | 530 | 531 | 532 | 533 | 534 | 535 | 536 | 537 | 538 | 539 | 540 | 541 | 542 | 543 | 544 | 545 | 546 | 547 | 548 | 549 | 550 | 551 | 552 | 553 | 554 | 555 | 556 | 557 | 558 | 559 | 560 | 561 | 562 | 563 | 564 | 565 | 566 | 567 | 568 | 569 | 570 | 571 | 572 | 573 | 574 | 575 | 576 | 577 | 578 | 579 | 580 | 581 | 582 | 583 | 584 | 585 | 586 | 587 | 588 | 589 | 590 | 591 | 592 | 593 | 594 | 595 | 596 | 597 | 598 | 599 | 600 | 601 | 602 | 603 | 604 | 605 | 606 | 607 | 608 | 609 | 610 | 611 | 612 | 613 | 614 | 615 | 616 | 617 | 618 | 619 | 620 | 621 | 622 | 623 | 624 | 625 | 626 | 627 | 628 | 629 | 630 | 631 | 632 | 633 | 634 | 635 | 636 | 637 | 638 | 639 | 640 | 641 | 642 | 643 | 644 | 645 | 646 | 647 | 648 | 649 | 650 | 651 | 652 | 653 | 654 | 655 | 656 | 657 | 658 | 659 | 660 | 661 | 662 | 663 | 664 | 665 | 666 | 667 | 668 | 669 | 670 | 671 | 672 | 673 | 674 | 675 | 676 | 677 | 678 | 679 | 680 | 681 | 682 | 683 | 684 | 685 | 686 | 687 | 688 | 689 | 690 | 691 | 692 | 693 | 694 | 695 | 696 | 697 | 698 | 699 | 700 | 701 | 702 | 703 | 704 | 705 | 706 | 707 | 708 | 709 | 710 | 711 | 712 | 713 | 714 | 715 | 716 | 717 | 718 | 719 | 720 | 721 | 722 | 723 | 724 | 725 | 726 | 727 | 728 | 729 | 730 | 731 | 732 | 733 | 734 | 735 | 736 | 737 | 738 | 739 | 740 | 741 | 742 | 743 | 744 | 745 | 746 | 747 | 748 | 749 | 750 | 751 | 752 | 753 | 754 | 755 | 756 | 757 | 758 | 759 | 760 | 761 | 762 | 763 | 764 | 765 | 766 | 767 | 768 | 769 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 780 | 781 | 782 | 783 | 784 | 785 | 786 | 787 | 788 | 789 | 790 | 791 | 792 | 793 | 794 | 795 | 796 | 797 | 798 | 799 | 800 | 801 | 802 | 803 | 804 | 805 | 806 | 807 | 808 | 809 | 810 | 811 | 812 | 813 | 814 | 815 | 816 | 817 | 818 | 819 | 820 | 821 | 822 | 823 | 824 | 825 | 826 | 827 | 828 | 829 | 830 | 831 | 832 | 833 | 834 | 835 | 836 | 837 | 838 | 839 | 840 | 841 | 842 | 843 | 844 | 845 | 846 | 847 | 848 | 849 | 850 | 851 | 852 | 853 | 854 | 855 | 856 | 857 | 858 | 859 | 860 | 861 | 862 | 863 | 864 | 865 | 866 | 867 | 868 | 869 | 870 | 871 | 872 | 873 | 874 | 875 | 876 | 877 | 878 | 879 | 880 | 881 | 882 | 883 | 884 | 885 | 886 | 887 | 888 | 889 | 890 | 891 | 892 | 893 | 894 | 895 | 896 | 897 | 898 | 899 | 900 | 901 | 902 | 903 | 904 | 905 | 906 | 907 | 908 | 909 | 910 | 911 | 912 | 913 | 914 | 915 | 916 | 917 | 918 | 919 | 920 | 921 | 922 | 923 | 924 | 925 | 926 | 927 | 928 | 929 | 930 | 931 | 932 | 933 | 934 | 935 | 936 | 937 | 938 | 939 | 940 | 941 | 942 | 943 | 944 | 945 | 946 | 947 | 948 | 949 | 950 | 951 | 952 | 953 | 954 | 955 | 956 | 957 | 958 | 959 | 960 | 961 | 962 | 963 | 964 | 965 | 966 | 967 | 968 | 969 | 970 | 971 | 972 | 973 | 974 | 975 | 976 | 977 | 978 | 979 | 980 | 981 | 982 | 983 | 984 | 985 | 986 | 987 | 988 | 989 | 990 | 991 | 992 | 993 | 994 | 995 | 996 | 997 | 998 | 999 | 1000 | 1001 | 1002 | 1003 | 1004 | 1005 | 1006 | 1007 | 1008 | 1009 | 1010 | 1011 | 1012 | 1013 | 1014 | 1015 | 1016 | 1017 | 1018 | 1019 | 1020 | 1021 | 1022 | 1023 | 1024 | 1025 | 1026 | 1027 | 1028 | 1029 | 1030 | 1031 | 1032 | 1033 | 1034 | 1035 | 1036 | 1037 | 1038 | 1039 | 1040 | 1041 | 1042 | 1043 | 1044 | 1045 | 1046 | 1047 | 1048 | 1049 | 1050 | 1051 | 1052 | 1053 | 1054 | 1055 | 1056 | 1057 | 1058 | 1059 | 1060 | 1061 | 1062 | 1063 | 1064 | 1065 | 1066 | 1067 | 1068 | 1069 | 1070 | 1071 | 1072 | 1073 | 1074 | 1075 | 1076 | 1077 | 1078 | 1079 | 1080 | 1081 | 1082 | 1083 | 1084 | 1085 | 1086 | 1087 | 1088 | 1089 | 1090 | 1091 | 1092 | 1093 | 1094 | 1095 | 1096 | 1097 | 1098 | 1099 | 1100 | 1101 | 1102 | 1103 | 1104 | 1105 | 1106 | 1107 | 1108 | 1109 | 1110 | 1111 | 1112 | 1113 | 1114 | 1115 | 1116 | 1117 | 1118 | 1119 | 1120 | 1121 | 1122 | 1123 | 1124 | 1125 | 1126 | 1127 | 1128 | 1129 | 1130 | 1131 | 1132 | 1133 | 1134 | 1135 | 1136 | 1137 | 1138 | 1139 | 1140 | 1141 | 1142 | 1143 | 1144 | 1145 | 1146 | 1147 | 1148 | 1149 | 1150 | 1151 | 1152 | 1153 | 1154 | 1155 | 1156 | 1157 | 1158 | 1159 | 1160 | 1161 | 1162 | 1163 | 1164 | 1165 | 1166 | 1167 | 1168 | 1169 | 1170 | 1171 | 1172 | 1173 | 1174 | 1175 | 1176 | 1177 | 1178 | 1179 | 1180 | 1181 | 1182 | 1183 | 1184 | 1185 | 1186 | 1187 | 1188 | 1189 | 1190 | 1191 | 1192 | 1193 | 1194 | 1195 | 1196 | 1197 | 1198 | 1199 | 1200 | 1201 | 1202 | 1203 | 1204 | 1205 | 1206 | 1207 | 1208 | 1209 | 1210 | 1211 | 1212 | 1213 | 1214 | 1215 | 1216 | 1217 | 1218 | 1219 | 1220 | 1221 | 1222 | 1223 | 1224 | 1225 | 1226 | 1227 | 1228 | 1229 | 1230 | 1231 | 1232 | 1233 | 1234 | 1235 | 1236 | 1237 | 1238 | 1239 | 1240 | 1241 | 1242 | 1243 | 1244 | 1245 | 1246 | 1247 | 1248 | 1249 | 1250 | 1251 | 1252 | 1253 | 1254 | 1255 | 1256 | 1257 | 1258 | 1259 | 1260 | 1261 | 1262 | 1263 | 1264 | 1265 | 1266 | 1267 | 1268 | 1269 | 1270 | 1271 | 1272 | 1273 | 1274 | 1275 | 1276 | 1277 | 1278 | 1279 | 1280 | 1281 | 1282 | 1283 | 1284 | 1285 | 1286 | 1287 | 1288 | 1289 | 1290 | 1291 | 1292 | 1293 | 1294 | 1295 | 1296 | 1297 | 1298 | 1299 | 1300 | 1301 | 1302 | 1303 | 1304 | 1305 | 1306 | 1307 | 1308 | 1309 | 1310 | 1311 | 1312 | 1313 | 1314 | 1315 | 1316 | 1317 | 1318 | 1319 | 1320 | 1321 | 1322 | 1323 | 1324 | 1325 | 1326 | 1327 | 1328 | 1329 | 1330 | 1331 | 1332 | 1333 | 1334 | 1335 | 1336 | 1337 | 1338 | 1339 | 1340 | 1341 | 1342 | 1343 | 1344 | 1345 | 1346 | 1347 | 1348 | 1349 | 1350 | 1351 | 1352 | 1353 | 1354 | 1355 | 1356 | 1357 | 1358 | 1359 | 1360 | 1361 | 1362 | 1363 | 1364 | 1365 | 1366 | 1367 | 1368 | 1369 | 1370 | 1371 | 1372 | 1373 | 1374 | 1375 | 1376 | 1377 | 1378 | 1379 | 1380 | 1381 | 1382 | 1383 | 1384 | 1385 | 1386 | 1387 | 1388 | 1389 | 1390 | 1391 | 1392 | 1393 | 1394 | 1395 | 1396 | 1397 | 1398 | 1399 | 1400 | 1401 | 1402 | 1403 | 1404 | 1405 | 1406 | 1407 | 1408 | 1409 | 1410 | 1411 | 1412 | 1413 | 1414 | 1415 | 1416 | 1417 | 1418 | 1419 | 1420 | 1421 | 1422 | 1423 | 1424 | 1425 | 1426 | 1427 | 1428 | 1429 | 1430 | 1431 | 1432 | 1433 | 1434 | 1435 | 1436 | 1437 | 1438 | 1439 | 1440 | 1441 | 1442 | 1443 | 1444 | 1445 | 1446 | 1447 | 1448 | 1449 | 1450 | 1451 | 1452 | 1453 | 1454 | 1455 | 1456 | 1457 | 1458 | 1459 | 1460 | 1461 | 1462 | 1463 | 1464 | 1465 | 1466 | 1467 | 1468 | 1469 | 1470 | 1471 | 1472 | 1473 | 1474 | 1475 | 1476 | 1477 | 1478 | 1479 | 1480 | 1481 | 1482 | 1483 | 1484 | 1485 | 1486 | 1487 | 1488 | 1489 | 1490 | 1491 | 1492 |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

06060

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06056

|  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Edgar Eugene Hoffman</b>  |  |  | 2a. DATE OF DEATH<br>April Month 11, Day 1969 Year                 |   |  | 2b. HOUR<br>12:30 AM  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>Nov. 16, 1906</b>  |  | 6. AGE (In years last birthday)<br><b>62</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Mt. Lena, Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Washington</b> Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Hagerstown</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTE (If not in hospital give street address)<br><b>Washington Co, Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Foreman</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Washington</b>   |  | 13c. CITY OR TOWN<br><b>Boonsboro</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>Rfd. 2</b>                          |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>Albert M. Hoffman</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Martha Lum</b> |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)<br><b>No.</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217-09-9693</b>   |  | 17. INFORMANT<br>Address<br><b>Mrs. Edna L. Hoffman, Rfd. 2, Boonsboro, Md.</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br><b>4201</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>3 yr</b> |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                 |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 3, 1966</b> , to <b>April 3, 1969</b> , that (I) (we) lost saw the deceased alive on <b>3/18/69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Robert V. H. Campbell</b>   |  | DEGREE<br><b>Robt. V. H. Campbell</b>  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>4/12/69</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Robt. V. H. Campbell</b>  |  | 22e. ADDRESS<br><b>Hagerstown Md</b>   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>4-13-69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Lena Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Mt. Lena, Wash. Co., Md.</b>                |  |  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>John H. Best, Jr. 112 N. Main St. Boonsboro, Md.</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br><b>APR 15 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John H. Best, Jr.</b>  |  |  |  |

03020



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove color papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                  |   |                                   |  |  |  |                       |
|---|------------------|---|-----------------------------------|--|--|--|-----------------------|
| 06061   |                  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |                                   |  |  | 06057  |                       |
| Item 2a Film 411 4/11/69 kk   |                  |   |                                   |  |  |  |                       |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>REV. CHARLES A. HUYETTE   |                  |   |                                   |  | 2a. DATE OF DEATH Month Day Year<br>April 2 1969 |  | 2b. HOUR<br>12" 30 AM |
| 3. SEX<br>Male  | 4. RACE<br>White |   | 5. DATE OF BIRTH<br>Oct. 11, 1873 |  | 6. AGE (In years last birthday)<br>95 YRS.       | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN                                       |                       |
| 7a. BIRTHPLACE (State or foreign country)<br>Penna.   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |                                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Washington Md.   |                       |
| 10. CITY OR TOWN OF DEATH<br>Williamsport R.1   |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Home Wood Church Home                                     |                                   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Clergyman   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Retired   |                       |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Penna.   |                  | 13b. CITY OR TOWN<br>Huntington   |                                   | 13c. CITY OR TOWN<br>Alexander   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                       |
| 13e. STREET AND NUMBER  |                  | 14. FATHER'S NAME First Middle Last<br>Scott Huyette  |                                   | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Laura B. Neff  |  |  |                       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br>No  |                  | 16b. SOCIAL SECURITY NO.<br>185-30-4260   |                                   | 17. INFORMANT Address<br>Rev. Mark G. Wagner Homewood Church Home  |  |  |                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>arteriosclerotic Cardio Vascular Dis</u><br>4124 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Senility</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 years |                  |   |                                   |  |  |  |                       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |                  |   |                                   |  |  |  |                       |
| 19a. DATE OF OPERATION  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |                  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19  |                                   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |                       |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |                  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |                                   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |                       |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Mar 24</u> , 19 <u>69</u> , to <u>April 2</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>March 31</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |                  |   |                                   |  |  |  |                       |
| 22b. SIGNATURE<br><u>A. E. W. H. T. To Jr</u>   |                  | DEGREE ATTENDING PHYS.<br><input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                   | 22c. DATE SIGNED<br>4-2-69   |  |  |                       |
| 22d. PHYSICIAN'S NAME (Type)<br><u>A. E. W. H. T. To Jr</u>   |                  | 22e. ADDRESS<br><u>202 W. Washington</u>  |                                   |  |  |  |                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                  | 23b. DATE<br>1969 April 5,  |                                   | 23c. NAME OF CEMETERY OR CREMATORY<br>Arch Spring Cemetery   |  | 23d. LOCATION (City or Town) (County) (State)<br>Tyrone, Pa. Blair Co. R.D. 1                |                       |
| 24. FUNERAL DIRECTOR<br>Andrew K. Coffman   |                  | Hagerstown, Md. ADDRESS   |                                   | 25a. REC'D BY REGISTRAR<br>DATE APR 7 1969   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |                       |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

06062

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06058

CERTIFICATE OF DEATH

|  |  |   |   |   |   |   |  |  |  |  |  |
|--|--|---|---|---|---|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <u>Gra</u>   |  |   | 2a. DATE OF DEATH<br>Month <u>April</u> Day <u>6</u> Year <u>1969</u>                                     |   |   | 2b. HOUR<br><u>7 P.</u> M.  |  |  |  |  |  |
| 3. SEX<br><u>Male</u>  |  | 4. RACE<br><u>White</u>                       |   | 5. DATE OF BIRTH<br><u>May. 22, 1887</u>  |   | 6. AGE (In years last birthday)<br><u>81</u> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u> |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><u>Washington</u> Md.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Boonsboro</u>  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><u>Fahrney-Keedy Home</u> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><u>Farm Owner</u>                    |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Farm</u>                             |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><u>Maryland</u>   |  |   | 13b. CITY OR TOWN<br><u>Frederick</u>   |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><u>Bussard Rd. Route 2</u> |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br><u>Charles Edward Ifert</u>   |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><u>Susan Rice</u>   |   |   |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <u>No</u>  |  |   | 16b. SOCIAL SECURITY NO.<br><u>215-36-6644</u>  |   | 17. INFORMANT<br><u>Lee F. Ifert</u>  |   |  | Address<br><u>Middletown, Md.</u>        |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u><br><u>4109</u> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____ DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |   |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                 |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?         |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <u>19</u>   |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 6, 1969</u> , to <u>April 6, 1969</u> , that (I) (we) last saw the deceased alive on <u>April 6, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                     |  |   |   |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>G. W. Wilson M.D.</u>   |  |   | DEGREE<br><u>M.D.</u>   |   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br><u>April 6, 1969</u>                                     |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>G. W. Wilson M.D.</u>   |  |   | 22e. ADDRESS<br><u>Boonsboro, Md.</u>   |   |   |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  |   | 23b. DATE<br><u>April 9, 69</u>   |   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Lutheran Cemetery</u>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Middletown Fred. Md.</u> |  |  |
| 24. FUNERAL DIRECTOR<br><u>Gladhill Company</u>  |  |   | ADDRESS<br><u>Middletown, Md.</u>   |   |   | 25a. REC'D BY REGISTRAR<br><u>APR 10 1969</u>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                           |  |  |

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UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

|                        |  |
|------------------------|--|
| Name of Person or Firm |  |
| Address                |  |
| City                   |  |
| State                  |  |
| Zip                    |  |
| Telephone              |  |
| Business               |  |
| Home                   |  |
| Other                  |  |
| Occupation             |  |
| Education              |  |
| Experience             |  |
| References             |  |
| Remarks                |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06059

06063

CERTIFICATE OF DEATH

|  |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Claudia Amelia Jordan</b>   |  |   | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>27</b> Year <b>1969</b> |   |  | 2b. HOUR<br>M  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>May 13 1906</b>  |  | 6. AGE (In years last birthday)<br><b>62</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Pa.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Washington</b> Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Hagerstown</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Wash. Co. Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                                     |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>   |  | 13b. COUNTY<br><b>Washington</b>  |  | 13c. CITY OR TOWN<br><b>Williamsport</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>22 E. Potomac St.</b>               |  |
| 14. FATHER'S NAME First Middle Last<br><b>Harry Perry</b>  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Gertrude De Merse</b> |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-07-1230D</b>   |  | 17. INFORMANT Address<br><b>Mr. Roger A. Jordan Williamsport Md. RFD #1</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Septicemia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Cancer of breast</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hours</b><br><b>2 yrs.</b> |  |   |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Pulmonary embolus.</b>  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>March</b>  |  |  |  |  |  |
| 22a. I certify that (I) <b>(the hospital)</b> attended the deceased from <b>March 1969</b> , to <b>4.27.1969</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>4/26/1969</b> , and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(we)</b> did <b>(did not)</b> view the body after death.  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Richard E. Smith, M.D.</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE SIGNED <b>4/29/69</b>   |  |   |  |   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Richard E. Smith, M.D.</b>  |  |   |  |   | 22e. ADDRESS<br><b>998 Potomac Ave. Hagerstown, Maryland</b> |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>April 30-69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenlawn Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Williamsport Wash. Md.</b>       |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Albert L. Leaf Williamsport Md.</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>MAY 1 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                     |  |  |  |



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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06064

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06060

|   |                         |  |  |   |  |   |  |   |   |  |
|---|-------------------------|--|--|---|--|---|--|---|---|--|
| 1. DECEASED-NAME<br>(Type or Print)<br><b>Minta Naomi Kauffman</b>  |                         |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> Month <b>4</b> Day <b>14</b> Year <b>1969</b> |   |  | 2b. HOUR<br><b>6:55 P.M.</b>  |  |   |   |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>April 5, 1877</b>   | 6. AGE (In years last birthday)<br><b>92</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> | 2c. DATE PRONOUNCED DEAD<br>Month <b>4</b> Day <b>14</b> Year <b>1969</b>   |  |   | 2d. HOUR<br><b>6:55 P.M.</b>  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Roadside, Penna.</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Washington</b>   |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Hagerstown</b>  |                         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Washington Co. Hospital</b>         |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>                           |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |                         |  | 13b. COUNTY<br><b>Washington</b>   |   |  | 13c. CITY OR TOWN<br><b>Hagerstown</b>  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>37 Belview Ave.</b>  |                         |  | 14. FATHER'S NAME<br>First <b>John</b> Middle <b>Henry</b> Last <b>Bonebrake</b>                                       |   |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Catherine</b> Middle <b>Amanda</b> Last <b>Miller</b>  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>4369</b>  |   |  | 17. INFORMANT<br>ADDRESS <b>Hagerstown, Md.</b><br><b>Mr. Norman B. Kauffman 1104 Woodland Way</b>                                    |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Atherosclerosis, cerebral</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |                         |  |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Hours</b><br><br><b>Years</b>                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Fractured femur</b>  |                         |  |  |   |  |   |  |   |   |  |
| 19a. DATE OF OPERATION  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  |   |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/><br><b>7:00 P.M. 4/2/ 1969</b>   |                         |  | 21b. TIME OF INJURY Month, Day, Year<br><b>4/2/ 1969</b>   |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Fell in livingroom</b>                          |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                         |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Home</b>                            |   |  | 21f. LOCATION Street or R.F.D. No. <b>37 Belview Ave.,</b> City or Town <b>Hagerstown,</b> County <b>Washington,</b> State <b>Md.</b> |  |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |  |  |   |  |   |  |   |   |  |
| ACTUAL SIGNATURE<br><b>Howard N. Weeks</b>  |                         |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |  | 22b. DATE SIGNED<br><b>4/16/69</b>  |  |   |   |  |
| EXAMINER'S NAME (Type)<br><b>Howard N. Weeks, M.D.</b>  |                         |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |  | ADDRESS (Street, city, town, or county)<br><b>Washington</b>  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         |  | 23b. DATE<br><b>4/17/69</b>  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Haven Cemetery</b>  |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Hagerstown-Washington-Md.</b>               |  |
| 24. FUNERAL DIRECTOR<br><b>Wm. A. Host</b><br><b>Rest Haven Funeral Chapel Hagerstown, Md.</b>  |                         |  |  |   |  | 25a. REC'D BY REGISTRAR<br><b>APR 18 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Ochsler, Judge</b> |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| 06065  |  |  |  |   |  |  |  |   |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |  |  |  |  |  |  | 06061  |  |  |  |
| 1. DECEASED NAME<br>(Type or print) <b>NETTIE V. KNIPPENBERG</b>   |  |  |  |   |  |  |  |   |  |  |  | 2a. DATE OF DEATH<br><b>April</b> Month <b>24</b> Day <b>1969</b> <b>eor</b>  |  |  |  |   |  |  |  |  |  |  |  | 2b. HOUR<br><b>4:15</b> <b>p</b> <b>M</b>                                  |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  |  |  | 4. RACE<br><b>White</b>   |  |  |  | 5. DATE OF BIRTH<br><b>1-15-87</b>  |  |  |  | 6. AGE (In years last birthday)<br><b>82</b> YRS.   |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  |  |  | IF UNDER 24 HRS.<br>HOURS MIN                      |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. COUNTY OF DEATH<br><b>WASHINGTON</b> <b>Md.</b>  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>HAGERSTOWN</b>   |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>WESTERN MD. STATE HOSPITAL</b> |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housekeeper</b>   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home.</b>  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  |  |  | 13b. COUNTY<br><b>ALLEGANY</b>  |  |  |  | 13c. CITY OR TOWN<br><b>Cumberland</b>  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |  |  |  | 13e. STREET AND NUMBER<br><b>132 North Centre St.</b> <b>Cumberland</b> |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>First <b>William</b> Middle <b>VAN</b> Last <b>BUSKIRK</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>MAHABIE</b> Middle <b>MILLER</b> Last <b>MILLER</b>                          |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, No, or unknown) <b>No</b> (If yes give war or dates of service)  |  |  |  |   |  |  |  |   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>217-10-1506</b>     |  |  |  | 17. INFORMANT<br>Address<br><b>Application form To Chronic Disease Hop</b> |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive Hemiplegia</b><br><b>1420</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Metastatic Carcinoma in lungs</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Carcinoma of the Parotid Gland</b><br><b>1 year</b> |  |  |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 years</b>   |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Arteriosclerotic Heart Disease; nephrosclerosis, Emphysema of lungs</b>   |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 14, 1969</b> , to <b>April 24, 1969</b> , that (I) (we) last saw the deceased alive on <b>April 24, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Fe U. Porciuncula M.D.</b>  |  |  |  |   |  |  |  |   |  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>April 24, 1969</b>                               |  |  |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Fe U. Porciuncula</b>   |  |  |  |   |  |  |  |   |  |  |  | 22e. ADDRESS<br><b>Western Maryland State Hospital</b>  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  |  | 23b. DATE<br><b>4/27/69</b>   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Memorial Park</b>   |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland Allegany Maryland</b>  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Silcox-Merritt Funeral Service. Cumberland, Md</b>  |  |  |  |   |  |  |  |   |  |  |  | ADDRESS<br><b>21502</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br><b>APR 28 1969</b>                           |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |  |  |  |  |  |  |  |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

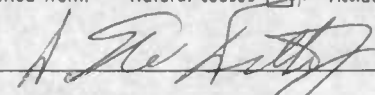

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06066

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06062

|  |                  |   |  |   |  |  |  |  |  |   |  |
|--|------------------|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or Print)  |                  | First<br>KEEFER   |  | Middle<br>MAIN  |  | Last<br>KOOGLE   |  | 2a. DATE KNOWN OF DEATH<br>M <input type="checkbox"/> Month Day Year<br>ESTI- MATED <input type="checkbox"/> April 7, 1969 |  | 2b. HOUR<br>6:55 P. M.                                      |  |
| 3. SEX<br>Male   | 4. RACE<br>White | 5. DATE OF BIRTH<br>August 14, 1902   |  | 6. AGE (In years last birthday)<br>66 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br>April 7, 1969 |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Washington Md.   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Hagerstown  |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Washington Co. Hospital             |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Retired |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Real Estate   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |                  | 13b. CITY<br>Frederick  |  | 13c. CITY OR TOWN<br>Frederick  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |  | 13e. STREET AND NUMBER<br>1500 W. Seventh Street   |  |   |  |
| 14. FATHER'S NAME First Middle Last<br>Frederick Koogle  |                  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Amanda Heffner  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) No   |                  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>214 34 1011                                    |  | 17. INFORMANT<br>Mrs. Natalie Koogle  |  | ADDRESS<br>1500 W. 7th St.   |  | Frederick Md.  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Fracture of skull</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>884X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Acute subdural hematoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 days |                  |   |  |   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)   |                  |   |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |                  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>11:38 AM 4-1- 19 69  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Fell from loading dock.  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br>Business Est. Frederick             |  | 21f. LOCATION Street or R.F.D. No.<br>Frederick Trading Co. Frederick, Frederick, Md.   |  | City or Town   |  | County   |  | State   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>         |                  |   |  |   |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE<br>  |                  | EXAMINER'S NAME (Type)<br>Dr. E. W. Ditto, Jr.  |  | 22b. DATE SIGNED<br>4-8-69  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |                  | 23b. DATE<br>April 11, 1969   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Olivet Cemetery   |  | 23d. LOCATION (City or Town) (County) (State)<br>Frederick Frederick Md.                           |  | 24. FUNERAL DIRECTOR<br>M. R. Etchison & Son, Frederick, Md.   |  |   |  |
| 25a. REC'D BY REGISTRAR<br>DATE<br>APR 11 1969   |                  | 25b. REGISTRAR'S SIGNATURE<br> |  |   |  |  |  |  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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06067

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06063

CERTIFICATE OF DEATH

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>HELEN SHIRLEY LEASURE</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>4</b> Day <b>10</b> Year <b>1969</b>                              |   | 2b. HOUR<br><b>5:10 P</b>  |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br><b>1/18/1895</b>  |   | 6. AGE (In years last birthday)<br><b>74</b> YRS.     | IF UNDER 1 YEAR<br>MONTHS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>VIRGINIA</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>WASHINGTON</b> Md.   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>HAGERSTOWN</b>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>WASHINGTON CO. HOSPITAL</b> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSEWIFE</b>   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b>  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>  | 13b. COUNTY<br><b>WASHINGTON</b>   | 13c. CITY OR TOWN<br><b>HAGERSTOWN</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER<br><b>WALNUT TOWERS</b>        |  |
| 14. FATHER'S NAME First Middle Last<br><b>NOT KNOWN</b>   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>NOT KNOWN</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>NO</b><br>(If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.  | 17. INFORMANT Address<br><b>HARRY LEASURE WALNUT TOWERS HAGERSTOWN MD.</b>                      |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intestinal Obstruction, Multiple</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Extensive Intra Abdominal Metastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Adenocarcinoma Sigmoid</b>                |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4-5 hours</b><br><b>2 years</b><br><b>Unknown</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>None</b>   |  |   |   |   |  |
| 19a. DATE OF OPERATION<br><b>Oct 1966</b>   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Adenocarcinoma Sigmoid</b>                              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 10, 1969</b> , to <b>April 10, 1969</b> , that (I) (we) last saw the deceased alive on <b>April 10, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |  |
| 22b. SIGNATURE<br><i>W. T. Layman, M.D.</i>   |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      | 22c. DATE SIGNED<br><b>April 11 69</b>  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>William T. Layman, M.D.</b>  |  | 22e. ADDRESS<br><b>301 E. Antietam Street, Hagerstown, Md.</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE<br><b>4/13/69</b>  | 23c. NAME OF CEMETERY<br><b>PINEY PLAINS METHODIST LITTLE ORLEANS</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>ALLEGANY MD.</b>                            |   |  |
| 24. FUNERAL DIRECTOR<br><i>Howard J. Moore</i>  |  | ADDRESS<br><i>Harrods Md</i>  | 25a. REC'D BY REGISTRAR<br><b>APR 17 1969</b>   | 25b. REGISTRAR'S SIGNATURE<br><i>William C. Under</i> |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|-------------------------------|--|--|--|--|
| CERTIFICATE OF DEATH  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                               |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  |  |  | First<br>SAMUEL   |  |  |  |  | Middle<br>HOWELL  |  |  |  |  | Last<br>LOHMAN  |  |  |  |  | 20. DATE OF DEATH<br>April 29 1969                                      |  |  |  |  | 2b. HOUR<br>M                 |  |  |  |  |
| 3. SEX<br>Male  |  |  |  |  | 4. RACE<br>White  |  |  |  |  | 5. DATE OF BIRTH<br>Oct. 18 1901  |  |  |  |  | 6. AGE (In years<br>last birthday)<br>67 YRS.   |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  |  |  |  | IF UNDER 24 HRS.<br>HOURS MIN |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Md.   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH<br>Washington Md.  |  |  |  |  |   |  |  |  |  |                               |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Hagerstown   |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Washington County Hospital |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Retail Store Owner  |  |  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Grocery Store   |  |  |  |  |   |  |  |  |  |                               |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE<br>Md.   |  |  |  |  | 13b. COUNTY<br>Washington   |  |  |  |  | 13c. CITY OR TOWN<br>Sharpsburg   |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER<br>121 W. Main St.                               |  |  |  |  |                               |  |  |  |  |
| 14. FATHER'S NAME<br>First<br>August  |  |  |  |  | Middle<br>Hc  |  |  |  |  | Last<br>Lohman  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First<br>Isa  |  |  |  |  | Middle<br>Florence  |  |  |  |  | Last<br>Creager               |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (or unknown)  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>220-16-3453   |  |  |  |  | 17. INFORMANT<br>Mrs Ruth I. Churchey Lohman  |  |  |  |  |   |  |  |  |  | Address<br>121 W. Main St.<br>Sharpsburg Md.                            |  |  |  |  |                               |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u><br>4109<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a).<br>stating the underlying cause<br>lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>2 WEEKS              |  |  |  |  |                               |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>SUSPECT PARTIAL BOWEL OBSTRUCTION</u>   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                               |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  |   |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |  |  |  |                               |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  |  |  |   |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)                 |  |  |  |  |   |  |  |  |  |                               |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                               |  |  |  |  |   |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                    |  |  |  |  |   |  |  |  |  |                               |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/17</u> , 1969, to <u>4/29</u> , 1969, that (I) (we) lost<br>saw the deceased alive on <u>4/29</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.                                 |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                               |  |  |  |  |
| 22b. SIGNATURE<br><u>R. Amarillo</u>  |  |  |  |  |   |  |  |  |  | DEGREE<br>ATTENDING<br>PHYS.<br><input checked="" type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/>       |  |  |  |  |   |  |  |  |  | 22c. DATE SIGNED<br><u>5/2/69</u>                                       |  |  |  |  |                               |  |  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>R. Amarillo, M. D.   |  |  |  |  |   |  |  |  |  | 22e. ADDRESS<br>120 W. Main St., Sharpsburg, Md. 21782  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |                               |  |  |  |  |
| 23a. BURIAL, CREMATION,<br>BURNING (Specify)  |  |  |  |  | 23b. DATE<br>May 3-69   |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt View Cemetery  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Sharpsburg Washington Md.                      |  |  |  |  |   |  |  |  |  |                               |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br>Albert L. Leaf Williamsport Md.  |  |  |  |  |   |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE<br>6 1969   |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |  |  |  |   |  |  |  |  |                               |  |  |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 7-66

| 06069   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                       |                                |   |  | 06065  |                   |
|---|--|---|--------------------------------|---|--|--|-------------------|
| CERTIFICATE OF DEATH  |  |   |                                |   |  |  |                   |
| 1. DECEASED-NAME<br>(Type or print) <b>Madeline</b>   |  |   | First Middle Last <b>Marks</b> |   | 2a. DATE OF DEATH<br>April Month 9 Day Year 1969 |  | 2b. HOUR<br>10:30 |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |                                | 5. DATE OF BIRTH<br><b>11/22/11</b>   |  | 6. AGE (In years lost birthday)<br><b>57</b> YRS.  |                   |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>WASHINGTON</b>  |                   |
| 10. CITY OR TOWN OF DEATH<br><b>HAGERSTOWN</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>WESTERN MD. STATE HOSPITAL</b> |                                | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>none</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>   |                   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Allegany</b>  |                                | 13c. CITY OR TOWN<br><b>Cumberland</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                   |
| 14. FATHER'S NAME First Middle Last<br><b>William F. Marks</b>  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Alta Heasley</b>   |                                | 13e. STREET AND NUMBER<br><b>637 Maryland Ave.</b>  |  |  |                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220-10-7914</b>  |                                | 17. INFORMANT Address<br><b>Mrs. Floyd Boor, Mt. Savage, Md. - Sister</b>   |  |  |                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the uterus with pulmonary metas-</b><br><b>1829</b> <b>tasis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>one year</b> |  |   |                                |   |  |  |                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |                                |   |  |  |                   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |                                | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |                   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |                                | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |                   |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>Feb. 3, 1969</b> , to <b>Apr. 9, 1969</b> , that (I) (we) saw the deceased alive on <b>April 9, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |                                |   |  |  |                   |
| 22b. SIGNATURE<br><b>Fe U. Porciuncula M.D.</b>   |  | 22c. DATE SIGNED<br><b>4/10/69</b>  |                                | 22d. ADDRESS<br><b>Western Maryland State Hospital<br/>1500 Pennsylvania Ave., Hagerstown, Md.</b>  |  |  |                   |
| 23a. BURIAL, CREMATION, or other (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>Apr. 12, 1969</b>   |                                | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Burial Park</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland, Allegany, Md.</b>            |                   |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>James F. Scarpelli, Cumberland, Md.</b>  |  |   |                                | 25a. REC'D BY REGISTRAR<br><b>APR 15 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |                   |

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Mr. Lloyd B. Smith, Jr., 1100 14th St., N.W., Washington, D.C.

Enclosed for the Bureau are two copies of the report of the

Commission on the Assassination of President Kennedy, dated April 12, 1969, and captioned "Report of the Commission on the Assassination of President Kennedy". The report contains information regarding the activities of the Commission and the results of its investigation. It is recommended that the report be distributed to the Bureau for its information and for its use in the conduct of its duties.

Very truly yours,  
John F. Kennedy  
President

James F. DeLoach, Jr., Chief of Staff  
April 12, 1969  
Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |   |  |   |   |  |  |  |                                |  |
|---|--|--|---|---|--|---|---|--|--|--|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |   |  |   |   |  |  |  |                                |  |
| CERTIFICATE OF DEATH  |  |  |   |   |  |   |   |  |  |  |                                |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>Anna May Martin</b>   |  |  |   |   |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>April 3 1969</b>  |   |  | 2b. HOUR<br><b>5 a.m.</b>                        |  |                                |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br><b>April 16 1892</b>  |  |   | 6. AGE (In years last birthday)<br><b>76</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                   |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S. A.</b>                               |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Washington</b> Md.   |   |  |  |  |                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Smithsburg</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Rural #2</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>House wife</b>                    |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b> |  |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  |  | 13b. COUNTY<br><b>Wash.</b>   |   | 13c. CITY OR TOWN<br><b>Smithsburg</b> |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER                           |  |                                |  |
| 14. FATHER'S NAME First Middle Last<br><b>Franklin M Strite</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Lydia Horst</b>  |  |   |   |  |  |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>no</b>  |   | 17. INFORMANT<br><b>Kenneth e Martin</b>  |  |   |   | Address<br><b>Smithsburg #2</b>                                      |  |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |   |   |  |   |   |  |  |  |                                |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |   |   |  |   |   |  |  |  |                                |  |
| IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b>  |  |  |   |   |  |   |   |  |  |  |                                |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |   |  |   |   |  |  |  |                                |  |
| (b) <b>Arteriosclerotic cardiovascular disease</b>  |  |  |   |   |  |   |   |  |  |  |                                |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |   |  |   |   |  |  |  |                                |  |
| (c)   |  |  |   |   |  |   |   |  |  |  |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |   |  |   |   |  |  |  |                                |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |  |  |  |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |  |  |  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-27</b> , 19 <b>55</b> , to <b>4-3</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>3-24</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |   |   |  |  |  |                                |  |
| 22b. SIGNATURE<br><b>Charles F. Hess M.D.</b> DEGREE  |  |  |   |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>4-3-69</b>                                    |  |  |                                |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Charles F. Hess, M.D.</b>  |  |  |   |   |  | 22e. ADDRESS<br><b>Smithsburg, Maryland 21783</b>   |   |  |  |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>April 5 69</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Stouffers Mennonite Cemetery</b>   |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Smithsburg Wash. md.</b>                    |  |  |  |                                |  |
| 24. FUNERAL DIRECTOR<br><b>Minnich Funeral Home</b>   |  | ADDRESS<br><b>Smithsburg Md.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>APR 8 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |  |  |  |                                |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06071

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06067

|   |  |   |   |   |  |   |  |  |  |
|---|--|---|---|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>CLARENCE W. MAYHUGH</b>  |  |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>APRIL 2 1969</b>          |   |  | 2b. HOUR<br><b>7P. M</b>  |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br><b>5/11/1902</b>  |  | 6. AGE (In years last birthday)<br><b>66</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Penna.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Washington</b> Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Hagerstown</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Wash. Co. Hospital and Maintenance Dept.</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Redesigner</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Penna.</b>  |  | 13b. COUNTY<br><b>Franklin</b>  |   | 13c. CITY OR TOWN<br><b>Rural</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>RD1 - Greencastle, Pa</b>           |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>FRANK Mayhugh</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Jennie Pool</b> |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or date of service)<br><b>177-16-0266</b>  |   | 17. INFORMANT<br><b>Mrs. Mary Mayhugh</b>   |  | Address<br><b>RD1 Greencastle</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4319</b> IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Atherosclerotic vascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>?</b> |  |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8 hrs.</b>    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |   | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County State   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/2/68</b> , 19__, to <b>4/2/69</b> , 19__, that (I) (we) last saw the deceased alive on <b>4/2/69</b> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>X</b> <b>W. C. BREWER, MD</b>  |  | DEGREE  |   | ATTENDING PHYS. <input checked="" type="checkbox"/>   |  | MED. DIRECTOR <input type="checkbox"/>  |  | STAFF PHYS. <input type="checkbox"/>                             |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS<br><b>Greencastle, Pa</b>  |   | 22c. DATE SIGNED<br><b>4/3/69</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>4/5/69</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Browns Hill Cem.</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Kau Hmay Station, Pa.</b>                   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>A. E. Mennich-Greencastle, Pa</b>  |  |   |   | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 7 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                 |  |

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APR 1 1963

06072

Item#13b,c,d,FilmGL12 5/14/69 km CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |  |        |         |  |  |  |  |  |  |
|---|--|--|--|--------|---------|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First  | Middle | Last    | 2a. DATE OF DEATH  |  |  | 2b. HOUR   |  |  |
| Baby Boy  |  |  |  |        | Ma Shaw | Month 4 Day 25 Year 69   |  |  | 9P M   |  |  |
| 3. SEX  |  |  | 4. RACE  |        |         | 5. DATE OF BIRTH   |  |  | 6. AGE (In years last birthday)  |  |  |
| m   |  |  | WHITE  |        |         | 4-28-69  |  |  | 6. AGE (In years last birthday) YRS. MONTHS DAYS 2 25  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |        |         | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH   |  |  |
| md  |  |  | USA  |        |         |  |  |  | Washington Md.   |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |        |         | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| Hagerstown  |  |  | Washington County Hosp   |        |         |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |        |         | 13c. CITY OR TOWN  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| md  |  |  | Washington   |        |         | Sharpsburg   |  |  | 13e. STREET AND NUMBER 113 S. Mechanic Street  |  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |        |         |  |  |  |  |  |  |
| Gene H  |  |  | McShaw   |        |         | Delores  |  |  | Lou  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)  |  |  | 16b. SOCIAL SECURITY NO.   |        |         | 17. INFORMANT  |  |  | Address  |  |  |
|   |  |  |  |        |         |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |        |         |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |        |         |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) immaturity  |  |  |  |        |         |  |  |  |  |  |  |
| 777X DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |        |         |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |        |         |  |  |  |  |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |        |         |  |  |  |  |  |  |
| (c)   |  |  |  |        |         |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |        |         |  |  |  |  |  |  |
| episode of vaginal bleeding of mother   |  |  |  |        |         |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |        |         | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |
|   |  |  |  |        |         |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |        |         | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |
|   |  |  |  |        |         |  |  |  |  |  |  |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |        |         | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |
|   |  |  |  |        |         |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/28, 1969, to 4/28, 1969, that (I) (we) last saw the deceased alive on 4/28, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |        |         |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  | DEGREE   |        |         | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                     |  |  | 22c. DATE SIGNED   |  |  |
| R. AMARILLO, M.D.   |  |  |  |        |         |  |  |  | 4/30/69  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  | 22e. ADDRESS   |        |         |  |  |  |  |  |  |
|   |  |  |  |        |         |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  | 23b. DATE  |        |         | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |
| CREMATION   |  |  | 5-1-69   |        |         | WASHINGTON COUNTY HOSPITAL   |  |  | HAGERSTOWN, MARYLAND   |  |  |
| 24. FUNERAL DIRECTOR  |  |  | ADDRESS  |        |         | 25a. REC'D BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |
| John S. Schaffer, Adm. Wash. Co. Hosp.  |  |  |  |        |         | MAY 6 1969   |  |  | Charles Judge  |  |  |

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UNITED STATES

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D.C.

July 1941

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WASHINGTON COUNTY HOSPITAL, WASHINGTON, D.C.

MAY 8 1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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|   |  |   |  |  |  |   |  |  |   |  |  |  |  |  |                                   |  |  |
|---|--|---|--|--|--|---|--|--|---|--|--|--|--|--|-----------------------------------|--|--|
| 06073   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  |  |  | 06069   |  |  |   |  |  |  |  |  |                                   |  |  |
| CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |  |   |  |  |  |  |  |                                   |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>Daniel</b>   |  |   | First <b>Webster</b>   |  |  | Middle <b>Mc Lucas</b>  |  |  | Lost  |  |  | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>26</b> Year <b>1969</b> |  |  | 2b. HOUR<br>M                     |  |  |
| 3. SEX<br><b>Male</b>   |  |   | 4. RACE<br><b>White</b>  |  |  | 5. DATE OF BIRTH<br><b>Sept. 4 1899</b>   |  |  | 6. AGE (In years last birthday)<br><b>69</b> YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS                                      |  |  | IF UNDER 24 HRS.<br>HOURS<br>MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   |  |   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Washington</b>   |  |  |  |  |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Williamsport</b>  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>110 S. Conococheague St. Williamsport</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Truckman</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>R. Road</b>   |  |  |  |  |  |                                   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>   |  |   | 13b. COUNTY<br><b>Washington</b>   |  |  | 13c. CITY OR TOWN<br><b>Williamsport</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>110 S. Conococheague St.</b>              |  |  |                                   |  |  |
| 14. FATHER'S NAME<br>First <b>Simon</b> Middle <b>H.</b> Last <b>Mc Lucas</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>Susan</b> Middle <b></b> Last <b>Weller</b>   |  |  |   |  |  |   |  |  |  |  |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>Yes</b><br>(If yes give war or dates of service) <b>World War #2</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>705-10-8023</b>   |  |  | 17. INFORMANT<br><b>110 S. Conococheague St. Williamsport Md.</b><br><b>Mrs. Joseph M. Anderson</b>   |  |  |   |  |  |  |  |  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>4/109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic Heart Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>General Arteriosclerosis</b> |  |   |  |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                           |  |  |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |   |  |  |   |  |  |  |  |  |                                   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |  |  |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |   |  |  |  |  |  |                                   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |  |  |  |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased alive on <b>4-21-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |  |   |  |  |  |  |  |                                   |  |  |
| 22b. SIGNATURE<br><b>Francis G. Rosillo</b>   |  |   | DEGREE <b>MD</b>   |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  |  | 22c. DATE SIGNED  |  |  |  |  |  |                                   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Francis G. Rosillo</b>   |  |   | 22e. ADDRESS<br><b>3807 Columbia Ave. Hagerstown Md.</b>   |  |  |   |  |  |   |  |  |  |  |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>April 29-69</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenlawn Cemetery</b>   |  |  | 23d. LOCATION (City or Town)<br><b>Williamsport</b>   |  |  | (County)<br><b>Wash.</b>   |  |  | (State)<br><b>Md.</b>             |  |  |
| 24. FUNERAL DIRECTOR<br><b>Albert L. Leaf</b>   |  |   | ADDRESS<br><b>Williamsport Md.</b>   |  |  | 25a. REC'D BY REGISTRAR<br><b>MAY 1 1969</b>  |  |  | DATE  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                       |  |  |                                   |  |  |



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RECEIVED

DATE: 1944

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

[illegible handwritten text]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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06074

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

06070

|  |  |                              |   |   |                                    |  |  |  |                                      |   |      |
|--|--|------------------------------|---|---|------------------------------------|--|--|--|--------------------------------------|---|------|
| 1. DECEASED-NAME<br>(Type or print)  |  |                              | First   | Middle  | Lost                               | 2a. DATE OF DEATH  |  |  | 2b. HOUR                             |   |      |
| Martha Louise Miller   |  |                              |   |   |                                    | 4 Month 17 Day 69 Year   |  |  | M                                    |   |      |
| 3. SEX   |  | 4. RACE                      |   | 5. DATE OF BIRTH  |                                    | 6. AGE (In years<br>last birthday)   |  | IF UNDER 1 YEAR  |                                      | IF UNDER 24 HRS.  |      |
| female   |  | white                        |   | 5-20-1903   |                                    | 65 YRS.  |  | MONTHS DAYS HOURS MIN  |                                      |   |      |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  | 7b. CITIZEN OF WHAT COUNTRY? |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. COUNTY OF DEATH   |  |  |                                      |   |      |
| Md.  |  | USA                          |   |   |                                    | Washington Md.   |  |  |                                      |   |      |
| 10. CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |   |                                    | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY |   |      |
| Hagerstown   |  |                              | 328 Central Ave.  |   |                                    | warper   |  |  | silk mill                            |   |      |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE   |  |                              | 13b. COUNTY   |   | 13c. CITY OR TOWN                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER               |   |      |
| Md.  |  |                              | Wash.   |   | Hagerstown                         |  | YES  |  | 328 Central Ave.                     |   |      |
| 14. FATHER'S NAME  |  |                              | First   | Middle  | Lost                               | 15. MOTHER'S MAIDEN NAME   |  |  | First                                | Middle  | Lost |
| Charles L. Miller  |  |                              |   |   |                                    | Glendora Staubs  |  |  |                                      |   |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)  |  |                              | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT                      |  |  | Address  |                                      |   |      |
| no   |  |                              | 216-09-7856A  |   | Charles H. H. Miller               |  |  | Hagerstown Md  |                                      |   |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Asystole</u><br>4121 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic Heart Disease</u><br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                              |   |   |                                    |  |  |  |                                      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>immediate</u> |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Nephrosclerosis with azotemia, Hypertension</u>  |  |                              |   |   |                                    |  |  |  |                                      |   |      |
| 19a. DATE OF OPERATION   |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?  |                                      |   |      |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |                              | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |   |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)            |  |  |                                      |   |      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |   |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State                               |  |  |                                      |   |      |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-3</u> , 1968, to <u>4-17</u> , 1969, that (I) (we) last<br>saw the deceased alive on <u>4-16</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.  |  |                              |   |   |                                    |  |  |  |                                      |   |      |
| 22b. SIGNATURE<br><u>Charles C. Spencer, M.D.</u>  |  |                              |   |   |                                    | DEGREE<br>M.D.   |  | ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/> |                                      | 22c. DATE SIGNED<br><u>4-18-69</u>                                  |      |
| 22d. PHYSICIAN'S<br>NAME (Type)  |  |                              |   |   |                                    | 22e. ADDRESS<br><u>145 S Prospect St Hagerstown, Md.</u>                                   |  |  |                                      |   |      |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  |                              | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY |  |  | 23d. LOCATION (City or Town) (County) (State)  |                                      |   |      |
| burial   |  |                              | 4-19-69   |   | Cedar Lawn Mem. Park               |  |  | Hagerstown, Md.  |                                      |   |      |
| 24. FUNERAL DIRECTOR   |  |                              |   |   |                                    | ADDRESS  |  | 25a. REC'D BY REGISTRAR  |                                      | 25b. REGISTRAR'S SIGNATURE  |      |
| Minnich Funeral Home   |  |                              |   |   |                                    | Hagerstown, Md.  |  | APR 21 1969  |                                      | <u>James J. J...</u>  |      |

4502

100

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06075

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06071

|  |         |                              |  |  |  |                 |  |   |  |   |  |   |  |                        |  |
|--|---------|------------------------------|--|--|--|-----------------|--|---|--|---|--|---|--|------------------------|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>RALPH</b>   |         | First                        |  | Middle   |  | Last            |  | 2a. DATE KNOWN OF DEATH   |  | Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> |  | 2b. HOUR  |  |                        |  |
|  |         |                              |  |  |  |                 |  | 24 20 1969  |  |   |  | 12 PM   |  |                        |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH             |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR |  | IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD  |  | 2d. HOUR  |  |                        |  |
| MALE   | WHITE   | MARCH 24, 1932               |  | 37 YRS.  |  | MONTHS DAYS     |  | HOURS MIN.  |  | Month 4 Day 23 Year 19 69   |  | 5 PM  |  |                        |  |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED   |  | NEVER MARRIED   |  | 9. COUNTY OF DEATH  |  |   |  |   |  |                        |  |
| MD   |         | U.S.A.                       |  | WIDOWED  |  | DIVORCED        |  | WASHINGTON  |  |   |  | Md.   |  |                        |  |
| 10. CITY OR TOWN OF DEATH  |         |                              |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                 |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                        |  |
| HAGERSTOWN   |         |                              |  | 437 W. CHURCH ST   |  |                 |  | ROOFER  |  |   |  | L.H. MINER, INC.  |  |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         |                              |  | 13b. COUNTY  |  |                 |  | 13c. CITY OR TOWN   |  |   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER |  |
| MD.  |         |                              |  | WASHINGTON   |  |                 |  | HAGERSTOWN  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 437 W. CHURCH ST.      |  |
| 14. FATHER'S NAME  |         |                              |  | 15. MOTHER'S MAIDEN NAME   |  |                 |  |   |  |   |  |   |  |                        |  |
| DANIEL   |         |                              |  | G. MUMMA   |  |                 |  | THERESA BELLE   |  |   |  | ZIMMERLY  |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         |                              |  | 16b. SOCIAL SECURITY NO.   |  |                 |  | 17. INFORMANT   |  |   |  | ADDRESS   |  |                        |  |
|  |         |                              |  | 217-28-1210  |  |                 |  | LOUISE R. MUMMA   |  |   |  | 437 W. CHURCH STREET  |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>gunshot wound neck &amp;</u><br><u>955X</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>trans. section C. Carotid Artery</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>&amp; Spinal Cord</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.    |         |                              |  |  |  |                 |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |                        |  |
|  |         |                              |  |  |  |                 |  |   |  |   |  | <u>Immed</u>  |  |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         |                              |  |  |  |                 |  |   |  |   |  |   |  |                        |  |
| 19a. DATE OF OPERATION   |         |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |  |                 |  | 20. AUTOPSY?  |  |   |  |   |  |                        |  |
|  |         |                              |  |  |  |                 |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  |   |  |   |  |                        |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |         |                              |  | 21b. TIME OF INJURY Month Day Year   |  |                 |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |  |   |  |   |  |                        |  |
|  |         |                              |  | 12 PM 4 PM 19 69   |  |                 |  | Self Inflicted gunshot wound  |  |   |  |   |  |                        |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |         |                              |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |                 |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |  |   |  |   |  |                        |  |
|  |         |                              |  | Home   |  |                 |  | 437 church st Hagerstown Wash Md  |  |   |  |   |  |                        |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                              |  |  |  |                 |  |   |  |   |  |   |  |                        |  |
| ACTUAL SIGNATURE   |         |                              |  | Schwarz W D M D.   |  |                 |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  | 22b. DATE SIGNED  |  |                        |  |
|  |         |                              |  |  |  |                 |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                     |  |   |  | 4-24-69   |  |                        |  |
| EXAMINER'S NAME (Type)   |         |                              |  | E.W. DITTO, 111 M.D. 217 WASH. ST.   |  |                 |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                             |  |   |  | ADDRESS (Street, city, town, or county)                             |  |                        |  |
|  |         |                              |  |  |  |                 |  |   |  |   |  |   |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         |                              |  | 23b. DATE  |  |                 |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |   |  | 23d. LOCATION (City or Town) (County) (State)                       |  |                        |  |
| BURIAL   |         |                              |  | 4-26-69  |  |                 |  | REST HAVEN CEMETERY   |  |   |  | HAGERSTOWN WASH. MD.  |  |                        |  |
| 24. FUNERAL DIRECTOR   |         |                              |  | ADDRESS  |  |                 |  | 25a. REC'D BY REGISTRAR   |  |   |  | 25b. REGISTRAR'S SIGNATURE  |  |                        |  |
| Charles M. Rouger  |         |                              |  | HAGERSTOWN, MD.  |  |                 |  | DATE APR 28 1969  |  |   |  | R. Charles Judge  |  |                        |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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06076

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06072

CERTIFICATE OF DEATH

|  |  |  |  |   |   |   |  |  |  |
|--|--|--|--|---|---|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>ALBERT S. Munson</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>4</b> Day <b>3</b> Year <b>1969</b>                      |   |   | 2b. HOUR<br><b>5P.</b>  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>Aug. 24, 1927</b>  |   | 6. AGE (In years lost birthday)<br><b>41</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Wash.</b>  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Hagerstown</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Wash. Co. Hosp.</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Truck Driver</b> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Truck, Inc.</b>          |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br><b>Penna.</b>   |  | 13b. COUNTY<br><b>Franklin</b>   |  | 13c. CITY OR TOWN<br><b>State Line</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |  | 13e. STREET AND NUMBER<br><b>P.O. Box 125</b>                    |  |
| 14. FATHER'S NAME<br>First <b>Beauford</b> Middle <b>Munson</b> Last <b>Munson</b>   |  |  | 15. MOTHER'S MARDEN NAME<br>First <b>Rhoda</b> Middle <b>Kinsey</b> Last <b>Kinsey</b> |   |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, (no or unknown) <b>No</b> (If yes give war and dates of service)            |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>215-20-7544</b>   |  |  | 17. INFORMANT<br><b>Mrs. Dorothy Munson</b>  |   |   | Address <b>State Line Pa.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute renal failure</b><br><b>4440</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Thrombosis of abdominal aorta</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arteriosclerotic vascular disease years</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>48 hr</b><br><b>48 hr</b> |  |  |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                      |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                           |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/14, 1969</b> , to <b>4/3, 1969</b> , that (I) (we) lost saw the deceased alive on <b>4/3, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>John R. Marsh M.D.</b>  |  |  |  | DEGREE<br><b>M.D.</b>   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4/4/69</b>                                |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>John R. Marsh</b>   |  |  |  | 22e. ADDRESS<br><b>Hagerstown, Md.</b>  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE<br><b>4/3/69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Co.</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>State Line Pa.</b>  |  | 23e. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>               |  |
| 24. FUNERAL DIRECTOR<br><b>A.C. Munnich - Greener</b>  |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 7 1969</b>   |   | 25b. REGISTRAR'S SIGNATURE  |  |  |  |

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RECEIVED OF THE

OFFICE OF THE SECRETARY OF THE ARMY



APR 1 1968

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 5 Film 311  
4/21/69 kk 06077

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06073

|  |  |         |                              |  |  |  |  |   |                |   |  |  |  |           |  |
|--|--|---------|------------------------------|--|--|--|--|---|----------------|---|--|--|--|-----------|--|
| 1. DECEASED-NAME<br>(Type or Print)  |  |         | First Middle Last            |  |  | 2a. DATE KNOWN OF DEATH                    |  |   | Month Day Year |   |  | 2b. HOUR                                     |  |           |  |
| JESSE BENJAMIN MURRAY  |  |         |                              |  |  | APRIL 8 1969                               |  |   |                |   |  | 11:00 P M                                    |  |           |  |
| 3. SEX   |  | 4. RACE |                              | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)            |  | IF UNDER 1 YEAR   |                | IF UNDER 24 HRS.                              |  | 2c. DATE PRONOUNCED DEAD                     |  | 2d. HOUR  |  |
| MALE   |  | WHITE   |                              | 2/22/1889  |  | 80 YRS.                                    |  | MONTHS DAYS   |                | HOURS MIN.                                    |  | Month Day Year                               |  | 11:00 P M |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |         | 7b. CITIZEN OF WHAT COUNTRY? |  |  | 8. MARRIED                                 |  |   | NEVER MARRIED  |   |  | 9. COUNTY OF DEATH                           |  |           |  |
| MARYLAND   |  |         | U.S.A.                       |  |  | WIDOWED                                    |  |   | DIVORCED       |   |  | WASHINGTON Md                                |  |           |  |
| 10. CITY OR TOWN OF DEATH  |  |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                |   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |           |  |
| HAGERSTOWN   |  |         |                              | WASHINGTON CO. HOSPITAL  |  |  |  | CARPENTER   |                |   |  |  |  |           |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |         |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN                          |  | 13d. INSIDE CITY LIMITS?  |                | 13e. STREET AND NUMBER                        |  |  |  |           |  |
| MARYLAND   |  |         |                              | WASHINGTON   |  | HAGERSTOWN                                 |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |                | RFD #2  |  |  |  |           |  |
| 14. FATHER'S NAME First Middle Last  |  |         |                              |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last |  |   |                |   |  |  |  |           |  |
| FRANKLIN MURRAY  |  |         |                              |  |  | SUSAN MILLS                                |  |   |                |   |  |  |  |           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |         |                              |  |  | 16b. SOCIAL SECURITY NO.                   |  | 17. INFORMANT ADDRESS   |                |   |  |  |  |           |  |
| NO   |  |         |                              |  |  | 220 34 0786                                |  | WILLIS L. MURRAY RFD #2 HAGERSTOWN, MD  |                |   |  |  |  |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |         |                              |  |  |  |  |   |                |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |           |  |
| PART 1. DEATH WAS CAUSED BY:   |  |         |                              |  |  |  |  |   |                |   |  | 4 hours.                                     |  |           |  |
| IMMEDIATE CAUSE (a) Shock, secondary to chest injury and   |  |         |                              |  |  |  |  |   |                |   |  |  |  |           |  |
| DUE TO, OR AS A CONSEQUENCE OF Multiple fractures of ribs,   |  |         |                              |  |  |  |  |   |                |   |  |  |  |           |  |
| (b) fracture right femur and left humerus.   |  |         |                              |  |  |  |  |   |                |   |  |  |  |           |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |                              |  |  |  |  |   |                |   |  |  |  |           |  |
| (c)  |  |         |                              |  |  |  |  |   |                |   |  |  |  |           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |         |                              |  |  |  |  |   |                |   |  |  |  |           |  |
| None   |  |         |                              |  |  |  |  |   |                |   |  |  |  |           |  |
| 19a. DATE OF OPERATION   |  |         |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |  |  |  | 20. AUTOPSY?  |                |   |  |  |  |           |  |
|  |  |         |                              |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |                |   |  |  |  |           |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH   |  |         |                              | 21b. TIME OF INJURY Month, Day, Year   |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |                |   |  |  |  |           |  |
|  |  |         |                              | 7:00 P.M. 4/8/1969   |  |  |  | Hit by car on road  |                |   |  |  |  |           |  |
| 21d. INJURY OCCURRED   |  |         |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |                |   |  |  |  |           |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |         |                              | Highway  |  |  |  | Route #40, West, Washington, Maryland   |                |   |  |  |  |           |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |         |                              |  |  |  |  |   |                |   |  |  |  |           |  |
| ACTUAL SIGNATURE   |  |         |                              | CHIEF MEDICAL EXAMINER   |  |  |  | 22b. DATE SIGNED  |                |   |  |  |  |           |  |
| EXAMINER'S NAME (Type)   |  |         |                              | DEPUTY MEDICAL EXAMINER  |  |  |  | 4/10/69   |                |   |  |  |  |           |  |
| Howard N. Weeks, M. D., 580 Northern Ave., Hagerstown, Md.   |  |         |                              |  |  |  |  |   |                |   |  |  |  |           |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |         |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY                      |  |   |                | 23d. LOCATION (City or Town) (County) (State) |  |  |  |           |  |
| BURIAL   |  |         |                              | 4/11/69  |  | PARKHEAD E.U.B.                            |  |   |                | BIG POOL WASH. MD.                            |  |  |  |           |  |
| 24. FUNERAL DIRECTOR   |  |         |                              | ADDRESS  |  |  |  | 25a. REC'D BY REGISTRAR   |                |   |  | 25b. REGISTRAR'S SIGNATURE                   |  |           |  |
| Howard F. Stone  |  |         |                              | HANCOCK, MD.   |  |  |  | APR 15 1969   |                |   |  | Charles Young                                |  |           |  |

APRIL 8 1964

MURRAY

BENJAMIN

LESLIE

MALE WHITE 2/22/1939 80

WASHINGTON

X

U.S.A.

MARYLAND

WASHINGTON CO, HOSPITAL CARPENTER

HAGERSTOWN

X RFO 42

HAGERSTOWN

WASHINGTON

MARYLAND

SUGAN MILLS

FRANKLIN MURRAY

200 34 0386 WILLIS L. MURRAY RFD 2 HAGERSTOWN, MD

XXXXXX

DIG POOL WASH. MD.

PARKHEAD E.U.S.

4/11/64

BURIAL

APR 11 1964

HANCOCK, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |  |   |  |  |   |  |
|--|--|--|--|---|--|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |  |  |   |  |
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |   |  |
| 1. DECEASED-NAME<br>(Type or print) <b>CECELIA HYACINTHE MYERS</b>   |  |  |  |   | 2a. DATE OF DEATH<br>Month <b>APRIL</b> Day <b>2</b> Year <b>1969</b>                                  |   | 2b. HOUR<br><b>9:10 A.M.</b>   |  |   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br><b>8/9/1886</b>   |  | 6. AGE (In years last birthday)<br><b>82</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.        |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>AUSTRIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>WASHINGTON</b>   |  | Md.  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>HAGERSTOWN</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>WASHINGTON CO. HOSPITAL</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSEWIFE</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b> |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  |  | 13b. CITY OR TOWN<br><b>WASHINGTON HAGERSTOWN</b>  |   | 13c. CITY OR TOWN<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |   | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><b>47 W. WILSON BLVD.</b> |  |
| 14. FATHER'S NAME First Middle Last<br><b>MITTERLANDER</b>   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>ANNE MARIE</b>  |   |  |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>149-05-7211A</b>  |   | 17. INFORMANT<br><b>MRS. DELIA R. FEIGLEY</b>  |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Heart Failure</b><br><b>4123</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Senile Arteriosclerosis</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Chronic Pyelonephritis</b> |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 1, 1969</b> , to <b>April 2, 1969</b> , that (I) (we) last saw the deceased alive on <b>April 2, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Francisco E. Rosillo</b>  |  |  |  | 22c. DATE SIGNED<br><b>April 3, 1969</b>  |  | 22d. PHYSICIAN'S NAME (Type)<br><b>Francisco E. Rosillo</b>   |  |  |   |  |
| 22e. ADDRESS<br><b>580 Northern Ave., Hagerstown, Md. 21740</b>  |  |  |  |   |  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, or other disposition (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>4/5/69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ROSE HILL CEM.</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>HAGERSTOWN WASH. MD.</b>                                |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>W. J. Normant, Hagerstown, Md.</b>  |  |  |  | 25a. REC'D BY REGISTRAR<br><b>APR 9 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. J...</b>  |  |  |   |  |



85020

SP 21/91

3-0175 - 5 - 11 - 1951 - 11 - 11 - 11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |                          |   |   |   |  |   |                                |
|---|--|--|--------------------------|---|---|---|--|---|--------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |                          |   |   |   |  |   |                                |
| 06079 CERTIFICATE OF DEATH 06075  |  |  |                          |   |   |   |  |   |                                |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last        |   |   | 2a. DATE OF DEATH   |  |   | 2b. HOUR                       |
| GERTRUDE  |  |  | ESTELLA                  |   |   | NEEDY   |  |   | April 12 1969 11.55            |
| 3. SEX  |  | 4. RACE  |                          | 5. DATE OF BIRTH  |   |   | 6. AGE (In years last birthday)  |   | IF UNDER 1 YEAR<br>MONTHS DAYS |
| Female  |  | White  |                          | July 31 1878  |   |   | 90 YRS.  |   | IF UNDER 24 HRS.<br>HOURS MIN  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |   | Md.                            |
| Maryland  |  | U.S.A.   |                          | Washington  |   |   |  |   |                                |
| 1d. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                       |                                |
| Hagerstown  |  | 1770 Jefferson Blvd  |                          |   | Housewife   |   |  | Own Home  |                                |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |                          | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER                                  |                                |
| Maryland  |  | Washington   |                          | Hagerstown  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 1770 Jefferson Blvd                                     |                                |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME |   |   |   |  |   |                                |
| First Middle Last   |  |  | First Middle Last        |   |   |   |  |   |                                |
| John Irvin Sprecher   |  |  | Annie E. Bowlus          |   |   |   |  |   |                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or unknown   |  |  | 16b. SOCIAL SECURITY NO. |   | 17. INFORMANT Address   |   |  |   |                                |
| No  |  |  | ---                      |   | Mrs Helen Bair 1770 Jefferson Blvd  |   |  |   |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4100 Myocardial infarction<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Hypertensive cardiovascular disease,<br>arteriosclerotic<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Indefinite          |  |  |                          |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>20 min. |                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |                          |   |   |   |  |   |                                |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          |   | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                   |   |                                |
|   |  |  |                          |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |   |  |   |                                |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |   |   |  |   |                                |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |   |                                |
|   |  |  |                          |   |   |   |  |   |                                |
| 22a. I certify that (I) (this hospital) attended the deceased from May 14, 1965, to April 12, 1969, that (I) (we) last saw the deceased alive on April 12, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                          |   |   |   |  |   |                                |
| 22b. SIGNATURE<br>B. B. Kneisley, M.D.  |  |  |                          |   | DEGREE<br>ATTENDING PHYS.   |   | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br>4/14/69    |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |                          |   | 22e. ADDRESS  |   |  |   |                                |
| B. B. Kneisley, M.D.  |  |  |                          |   | 148 West Washington Street<br>Hagerstown, Maryland                                      |   |  |   |                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY  |   |   | 23d. LOCATION (City or Town) (County) (State)  |   |                                |
| Burial  |  | 4/15/69  |                          | Rose Hill Cemetery  |   |   | Hagerstown Wash Co Md  |   |                                |
| 24. FUNERAL DIRECTOR  |  |  |                          |   | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE   |   |                                |
| Andrew K. Coffman Funeral Home Inc  |  |  |                          |   | APR 21 1969   |   | f Charles Judge  |   |                                |

00073

STATE OF NEW YORK

IN SENATE

11.11.1900

July 31 1899

Washington

1770 Jefferson Blvd

Washington

John Edwin Sprecher

Mrs Helen Blair 1770 Jefferson Blvd

Washington D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |   |   |  |   |   |                                      |                                |
|--|--|---|---|---|--|---|---|--------------------------------------|--------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |   |   |  |   |   |                                      |                                |
| 06080 CERTIFICATE OF DEATH 06076   |  |   |   |   |  |   |   |                                      |                                |
| 1. DECEASED-NAME<br>(Type or print)  |  |   | First   | Middle  | Last   | 2a. DATE OF DEATH<br>Month Day Year   |   |                                      | 2b. HOUR                       |
| Lottie   |  |   | G.  |   | Nihiser  | April 9, 1969   |   |                                      | 8:35P M                        |
| 3. SEX   |  | 4. RACE   |   | 5. DATE OF BIRTH  |  | 6. AGE (In years<br>last birthday)  |   | IF UNDER 1 YEAR<br>MONTHS DAYS       | IF UNDER 24 HRS.<br>HOURS MIN. |
| Female   |  | White   |   | Jan. 11, 1874   |  | 95 YRS.   |   |                                      |                                |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |   |                                      |                                |
| Keedysville, Md.   |  | U. S. A.  |   |   |  | Washington Md.  |   |                                      |                                |
| 10. CITY OR TOWN OF DEATH  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)      |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY |                                |
| Boonsboro  |  |   | Fahrney- Keedy Mem. Home  |   |  | Housewife   |   | Own Home                             |                                |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |  |   | 13b. COUNTY   |   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER  |                                      |                                |
| Maryland   |  |   | Washington  |   | Hagerstown   |   | 811 Mulberry Ave.   |                                      |                                |
| 14. FATHER'S NAME  |  |   | First   | Middle  | Last   | 15. MOTHER'S MAIDEN NAME  |   |                                      | First Middle Last              |
| Jacob  |  |   |   |   | Eavey  | Clementine  |   |                                      | Keedy                          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)  |  |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT  |   |   |                                      |                                |
| No.  |  |   | 213-48-7016   |   | Mrs. Edward W. Ditto, Jr. 1702s Cathedral Ave.<br>Hagerstown, Md.                    |   |   |                                      |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>4124 DUE TO, OR AS A CONSEQUENCE OF <u>arterio-sclerotic Cardio Vascular Les</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Cardio Vascular Les</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterio-sclerotic Cardio Vascular Les</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 days<br>5 years |  |   |   |   |  |   |   |                                      |                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |   |   |  |   |   |                                      |                                |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |                                      |                                |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)      |   |   |                                      |                                |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                         |   |   |                                      |                                |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-1-68, to 4-9-69, that (I) (we) last saw the deceased alive on 4-9-69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |   |   |                                      |                                |
| 22b. SIGNATURE<br>N. E. W. J. P. M. D.   |  | 22c. DATE SIGNED<br>4-10-69   |   |   | 22d. PHYSICIAN'S NAME (Type)<br>N. E. W. J. P. M. D.                                 |   |   |                                      |                                |
| 22e. ADDRESS<br>315 Washington Hagerstown Md   |  |   |   |   |  |   |   |                                      |                                |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)   |   |                                      |                                |
| Burial   |  | 4-12-69   |   | Fairview Cemetery   |  | Keedysville, Wash. Co., Md.   |   |                                      |                                |
| 24. FUNERAL DIRECTOR<br>ADDRESS  |  |   |   |   | 25a. REC'D BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE  |                                      |                                |
| John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.   |  |   |   |   | APR 14 1969  |   | Charles Judge   |                                      |                                |

08030



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

06081

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06077

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEASED-NAME<br>(Type or print) <b>PEARL ROBERTA REED</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>16</b> Year <b>1969</b> |   |  | 2b. HOUR <b>220</b> MIN <b>M</b>   |   |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>March 2 1901</b>   |  | 6. AGE (In years last birthday) <b>68</b> YRS.   |   |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Washington</b> Md.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Hagerstown</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Washington Co. Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Washington</b>   |  | 13c. CITY OR TOWN<br><b>Hagerstown</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 13e. STREET AND NUMBER<br><b>800 Dual Highway</b>  |  | 13f. CITY AND STATE<br><b>Hagerstown, Md.</b>  |  |   |  |  |   |
| 14. FATHER'S NAME First Middle Last<br><b>Henry E. Lum</b>   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Sarah Atherton</b>    |   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT Address<br><b>Roy H. Reed 800 Dual Highway Hagerstown, Md.</b>  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Extensive Intra-abdominal metastasis</b><br><b>1890</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Hypernephroma of right kidney</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>unknown</b> |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 months</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Hypertensive and Atherosclerotic Heart Disease. Arthritis, degenerative.</b>  |  |  |  |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 16</b> , 19 <b>69</b> , to <b>Apr 16</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>Apr 15</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |   |
| 22b. SIGNATURE<br><b>W. T. Layman, M.D.</b>  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  | 22c. DATE SIGNED<br><b>Apr 18 1969</b>   |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>William T. Layman, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>301 E. Antietam Street, Hagerstown, Md.</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/18/69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Hagerstown Wash Co Md.</b>               |   |
| 24. FUNERAL DIRECTOR<br><b>Hagerstown, Md. Andrew K. Coffman Funeral Home Inc.</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br><b>APR 21 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judala</b>  |   |

18081

ESTIMATE IN DEATH

230 10, 1952

March 2 1951

Washington

Washington

800 2nd Highway  
Washington, D.C.

Washington, D.C. x

Washington

John A. Norton

John A. Norton

800 2nd Highway  
Washington, D.C.

John

*John A. Norton*

1952

Washington, D.C. Inc.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |   |   |                   |  |   |   |                        |  |           |
|---|--|---|---|---|-------------------|--|---|---|------------------------|--|-----------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |   |                   |  |   |   |                        |  |           |
| 06082   |  |   |   |   | 06078             |  |   |   |                        |  |           |
| CERTIFICATE OF DEATH  |  |   |   |   |                   |  |   |   |                        |  |           |
| 1. DECEASED-NAME<br>(Type or print)   |  |   | First   | Middle  | Lost              | 2a. DATE OF DEATH  |   |   | 2b. HOUR               |  |           |
| William Howard Rensburg   |  |   | William   | Howard  | Rensburg          | April 13, 1969   |   |   | 4:50A M                |  |           |
| 3. SEX  |  | 4. RACE   |   | 5. DATE OF BIRTH  |                   | 6. AGE (In years<br>lost birthday)   |   | IF UNDER 1 YEAR<br>MONTHS DAYS  |                        |  |           |
| Male  |  | White   |   | Nov. 14, 1886   |                   | 82 YRS.  |   |   |                        |  |           |
| 7a. BIRTHPLACE (State or foreign<br>country)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. COUNTY OF DEATH   |   | Md  |                        |  |           |
| Sharpsburg, Md.   |  | U. S. A.  |   |   |                   | Washington   |   |   |                        |  |           |
| 10. CITY OR TOWN OF DEATH   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |   |                   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                    |                        |  |           |
| Hagerstown  |  |   | Washington Co. Hospital   |   |                   | Farmer   |   | Farming   |                        |  |           |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE  |  |   | 13b. CITY   |   | 13c. CITY OR TOWN |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER |  |           |
| Maryland  |  |   | Washington  |   | Keedysville       |  | YES   |   | 9 N. Main St.          |  |           |
| 14. FATHER'S NAME   |  |   | First   | Middle  | Lost              | 15. MOTHER'S MAIDEN NAME   |   |   | First                  | Middle   | Lost      |
| Hicks   |  |   | Hicks   |   |                   | Alice  |   |   |                        |  | Nicodemus |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown   |  |   | 16b. SOCIAL SECURITY NO.  |   |                   | 17. INFORMANT  |   |   | 110 Hoffman Ave.       |  |           |
| No.   |  |   | 214-36-2291   |   |                   | Mrs. Sarajane Young, Hagerstown, Md.   |   |   |                        |  |           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cerebral arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Exacerbated arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |   |   |                   |  |   |   |                        | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>2 wks.</u><br><u>yes</u><br><u>yes</u> |           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Right hemiplegia</u>   |  |   |   |   |                   |  |   |   |                        |  |           |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |   |                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |                        |  |           |
|   |  |   |   |   |                   |  |   |   |                        |  |           |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                   |  |   |   |                        |  |           |
|   |  |   |   |   |                   |  |   |   |                        |  |           |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No.  |                   | City or Town   |   | County  |                        | State  |           |
|   |  |   |   |   |                   |  |   |   |                        |  |           |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 11, 1969</u> to <u>late</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>11 April 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |                   |  |   |   |                        |  |           |
| 22b. SIGNATURE<br><u>Richard T. Binford</u>   |  |   |   |   |                   | ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED. <input type="checkbox"/> STAFF <input type="checkbox"/><br>DEGREE DIRECTOR PHYS. |   | 22c. DATE SIGNED<br><u>14 April 69</u>                                  |                        |  |           |
| 22d. PHYSICIAN'S<br>NAME (Type)   |  |   |   |   |                   | 22e. ADDRESS   |   |   |                        |  |           |
| Richard T. Binford, M. D.   |  |   |   |   |                   | 1135 Potomac Ave., Hagerstown, Md.   |   |   |                        |  |           |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY  |                   | 23d. LOCATION (City or Town)   |   | (County)  |                        | (State)  |           |
| Burial  |  | 4- 15- 69   |   | Bakersville Cemetery  |                   | Bakersville, Wash. Co., Md.  |   |   |                        |  |           |
| 24. FUNERAL DIRECTOR  |  |   |   |   |                   | ADDRESS  |   | 25a. RECEIVED BY REGISTRAR  |                        | 25b. REGISTRAR'S SIGNATURE   |           |
| John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.  |  |   |   |   |                   |  |   | APR 16 1969   |                        |  |           |

170

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1125 Vermont Ave., N.W., Washington, D.C.

2071-1985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06083

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

06079

|  |  |                              |  |   |                                    |  |   |  |                                   |  |       |
|--|--|------------------------------|--|---|------------------------------------|--|---|--|-----------------------------------|--|-------|
| 1. DECEASED-NAME<br>(Type or print)  |  |                              | First  | Middle  | Last                               | 2a. DATE OF DEATH<br>Month Day Year  |   |  | 2b. HOUR<br>M                     |  |       |
| Anna   |  |                              | Grace  |   | Reynolds                           | April 29 1969  |   |  |                                   |  |       |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH  |                                    | 6. AGE (In years last birthday)  |   | IF UNDER 1 YEAR<br>MONTHS DAYS                                       |                                   | IF UNDER 24 HRS.<br>HOURS MIN.                               |       |
| Female   |  | White                        |  | Feb. 25 1891  |                                    | 78 YRS.  |   |  |                                   |  |       |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. COUNTY OF DEATH   |   |  |                                   |  |       |
| Maryland   |  | USA.                         |  |   |                                    | Washington Md.   |   |  |                                   |  |       |
| 10. CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |       |
| Boonsboro  |  |                              | Fairney Keedy Home   |   |                                    | housewife  |   |  | home                              |  |       |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE  |  |                              | 13b. COUNTY  |   | 13c. CITY OR TOWN                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER            |  |       |
| Maryland.  |  |                              | Washington   |   | Smithsburg                         |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |  | RFD. # 2                          |  |       |
| 14. FATHER'S NAME  |  |                              | First  | Middle  | Last                               | 15. MOTHER'S MAIDEN NAME   |   |  | First                             | Middle   | Last  |
| D. T.  |  |                              |  |   | Stockslager                        | Emma   |   |  | K                                 |  | Shank |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  |                              | (If yes give war or dates of service)  |   | 16b. SOCIAL SECURITY NO.           |  | 17. INFORMANT Address   |  |                                   |  |       |
| no   |  |                              | no   |   | 215-36-6962                        |  | Harold H Reynolds Smithsburg RFD. #   |  |                                   |  |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cancer of intestines</u><br><u>1829</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                              |  |   |                                    |  |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 yrs</u> |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |                              |  |   |                                    |  |   |  |                                   |  |       |
| 19a. DATE OF OPERATION   |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |  |       |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |                              | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |   |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |                                   |  |       |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |                                   |  |       |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 4, 1969</u> , to <u>April 29, 1969</u> , that (I) (we) last saw the deceased alive on <u>April 29, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                         |  |                              |  |   |                                    |  |   |  |                                   |  |       |
| 22b. SIGNATURE <u>G. W. Van N. S.</u>  |  |                              |  |   |                                    | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED <u>May 2, 1969</u>                                  |                                   |  |       |
| 22d. PHYSICIAN'S NAME (Type) <u>G. W. Van N. S.</u>  |  |                              |  |   |                                    | 22e. ADDRESS <u>Boonsboro Md.</u>  |   |  |                                   |  |       |
| 23a. BURIAL, CREMATION, REMOVAL  |  |                              | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION (City or Town) (County) (State)   |  |                                   |  |       |
| Smithsburg Md.   |  |                              | May 2 1969   |   | Smithsburg Cemetery                |  | Smithsburg Wash. Md.  |  |                                   |  |       |
| 24. FUNERAL DIRECTOR ADDRESS   |  |                              |  |   |                                    | 25a. REC'D BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |                                   |  |       |
| Minnich Funeral Home Smithsburg Md.  |  |                              |  |   |                                    | DATE MAY 5 1969  |   | <u>Charles Judge</u>   |                                   |  |       |



38030

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

06084

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

06080

|   |  |  |   |   |  |   |   |  |   |       |   |  |
|---|--|--|---|---|--|---|---|--|---|-------|---|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>Meridith</b>  |  |  | First Middle Last   |   |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>April 4, 1969</b>   |   |  | 2b. HOUR<br><b>8:30a M</b>                    |       |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br><b>November 18, 1879</b>  |  |   | 6. AGE (In years last birthday)<br><b>89</b> YRS.                                 |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>4 16</b> |       | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>4 16</b> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Smithsburg</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Washington</b>   |   |  | Md.   |       |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Smithsburg</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Route # 2</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Farmer</b> |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                 |   |       |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Washington</b>   |   | 13c. CITY OR TOWN<br><b>Smithsburg</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |   | 13e. STREET AND NUMBER<br><b>Route # 2</b>                           |   |       |   |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>Alexander Ridenour</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Susan Kline</b> |   |  |   |   |  |   |       |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213-50-4014</b>   |   | 17. INFORMANT<br><b>Mrs. John Coyle, Route # 2, Smithsburg, Md.</b>   |  |   | Address   |  |   |       |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b><br><b>4124</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Atrial fibrillation</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>Arteriosclerotic cardiovascular disease</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hours</b><br><b>1 year</b><br><b>8 years</b> |  |  |   |   |  |   |   |  |   |       |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)  |  |  |   |   |  |   |   |  |   |       |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |       |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |  |   |       |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                     |   | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |   | County   |   | State |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-20</b> , 19 <b>55</b> , to <b>4-4</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1-28</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |   |   |  |   |       |   |  |
| 22b. SIGNATURE<br><b>Charles F. Hess</b>  |  |  |   | M.D. DEGREE   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>4-4-69</b>                                    |   |       |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Charles F. Hess, M.D.</b>  |  |  |   | 22e. ADDRESS<br><b>Smithsburg, Maryland 21783</b>   |  |   |   |  |   |       |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>4-7-69</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cavetown Cemetery</b>  |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Cavetown, Washington, Md.</b> |  |   |       |   |  |
| 24. FUNERAL DIRECTOR<br><b>John H. Bast, Jr. 112 N. Main St, Boonsboro, Md.</b>   |  |  |   | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br><b>APR 8 1969</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                   |   |       |   |  |

48090

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

| MARTLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |   |   |   |  |  |
|---|--|---|--|---|---|---|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |   |   |   |  |  |
| 06085 CERTIFICATE OF DEATH 06081  |  |   |  |   |   |   |   |  |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>HOLMES EGGLESTON CONRAD RUSSELL</b>   |  |   |  |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>APRIL 17 69</b>                 |   |   | 2b. HOUR<br><b>5:15 PM</b>   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br><b>SEPTEMBER 11, 1879</b>   |   | 6. AGE (In years<br>last birthday)<br><b>89</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN                    |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>VIRGINIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>WASHINGTON</b> Md.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>HAGERSTOWN</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>GARLOCK CON. HOME</b> |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>RETIRED ENGR.</b>  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>P.R.R.</b>   |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>WASHINGTON</b>  |  | 13c. CITY OR TOWN<br><b>HAGERSTOWN</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>633 HIGHLAND WAY</b>                                  |  |
| 14. FATHER'S NAME First Middle Last<br><b>JOHN WILLIAM RUSSELL</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>MARTHA LUPTON</b>  |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)   |  | 17. INFORMANT Address<br><b>ROBERT C. RUSSELL UNION, N.J.</b>   |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonitis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic Cardio Vascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. <b>4124</b> |  |   |  |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>4 days</b><br><b>5 years</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                             |  | 21f. LOCATION Street or R.F.D. No.  |   | City or Town  |   | County State   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 1, 1966</b> to <b>April 17, 1969</b> , that (I) (we) last<br>saw the deceased alive on <b>April 15, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |   |   |  |  |
| 22b. SIGNATURE<br><b>E.W. DITTO, JR. M.D.</b>   |  |   |  | DEGREE ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/>                |   | 22c. DATE SIGNED<br><b>April 18, 1969</b>   |   |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>E.W. DITTO, JR. M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>215 W. WASHINGTON STREET</b>   |   |   |   |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>APRIL 20, 1969</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GREEN HILL CEMETERY</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>BERRYVILLE CLARKE VA.</b>                   |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Stallinmeyer</b>   |  |   |  | ADDRESS<br><b>HAGERSTOWN, MD.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>APR 23 1969</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>William J. ...</b>                                |  |





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06086

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06082

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>John Wesley Sensenbaugh</b>  |   |   | 2a. DATE OF DEATH<br><b>April 21, 1969</b>  |   | 2b. HOUR<br><b>M</b>   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br><b>October 18, 1905</b>   |   | 6. AGE (In years last birthday)<br><b>63</b> YRS.                                   | IF UNDER 1 YEAR<br>MONTHS<br>OAYS<br>HOURS<br>MIN.               |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Washington</b>   |   | Md.  |
| 1d. CITY OR TOWN OF DEATH<br><b>Hagerstown</b>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>2417 Virginia Ave.</b> | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)<br><b>Auto mechanic</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Garage</b>                                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  | 13b. COUNTY<br><b>Washington</b>  | 13c. CITY OR TOWN<br><b>Hagerstown</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 13e. STREET AND NUMBER<br><b>2417 Virginia Ave.</b>                                 |  |
| 14. FATHER'S NAME<br>First <b>Daniel</b> Middle <b>Thomas</b> Last <b>Sensenbaugh</b>   |   | 15. MOTHER'S MAIDEN NAME<br>First <b>Dessie</b> Middle <b>Schrader</b> Last <b>Schrader</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service) <b>218-22-0672</b>  |   | 17. INFORMANT<br><b>2417 Virginia Ave. Mrs. Lurena Sensenbaugh Hagerstown, Md.</b>  |  |
| 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Primary Amyloidosis</b><br><b>276x</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 1/2 yrs</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Atherosclerosis, Cerebral &amp; Generalized. Bilateral Cataracts. Glaucoma. Degenerative Arthritis.</b>  |   |   |   |   |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 11</b> , 19 <b>69</b> , to <b>Apr 21</b> , 19 <b>69</b> , that (I/we) last saw the deceased alive on <b>Apr 14</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I/we) (did) (did not) view the body after death.     |   |   |   |   |  |
| 22b. SIGNATURE<br><b>W. T. Layman</b>   |   |   | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED<br><b>Apr 21 1969</b>  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>William T. Layman, M.D</b>  |   |   | 22e. ADDRESS<br><b>301 E. Antietam St. Hagerstown, Md. 21740</b>  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE<br><b>April 23, 1969</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Manor Cemetery</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Near Tighmanton, Wash., Md.</b> |  |
| 24. FUNERAL DIRECTOR<br><b>Albert L. Leaf Williamsport, Maryland</b>  |   |   | 25a. REC'D BY REGISTRAR<br><b>APR 24 1969</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>               |

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UNITED STATES DEPARTMENT OF THE INTERIOR

OFFICE OF THE SECRETARY OF THE INTERIOR

*[Handwritten signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH   |   |  |   |
|---|---|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |   |  |   |
| 06087   |   | CERTIFICATE OF DEATH   |   |
| 06083   |   |  |   |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Washington</b><br>MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Washington</b>   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>RFD-2 Williamsport, Md.</b>                                       |   |
| c. LENGTH OF STAY IN 1b<br><b>9HRS.</b>   |   |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Washington County</b>  |   | d. STREET ADDRESS<br><b>RFD-2 Williamsport, Md.</b>  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Philip Archie Shirley</b>  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>April 1, 1969</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 31, 69</b>       |
| 9. AGE (In years last birthday)<br><b>9 yrs.</b>  |   | IF UNDER 1 YEAR<br>Months Days Hours Min.<br><b>9</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |   | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Washington, Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>Archie Glenn Shirley</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Ann Nave</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |   | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT<br><b>Archie Glenn Shirley, RD-2 Williamsport</b>   |   | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>prematurity</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>abruptio placentae</b><br>DUE TO<br>(c) |   | INTERVAL BETWEEN ONSET AND DEATH   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)          |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.  |   |  |   |
| 22a. SIGNATURE<br><b>John D. Turco</b>  |   | 22b. DATE SIGNED<br><b>4/2/69</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>John D. Turco, M. D.</b>   |   | 22d. ADDRESS<br><b>363 South Cleveland Avenue</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE THEREOF   | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION (City or Town) (County) (State) |
| <b>Burial</b>   | <b>April 3, 69</b>  | <b>Pinesburg Mennonite</b>   | <b>Pinesburg Wash. Md.</b>                    |
| 24. FUNERAL DIRECTOR<br><b>Thompson Funeral Home</b>  |   | 25a. REC'D BY REGISTRAR<br><b>APR 8 1969</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |  |   |

00007

STATE OF OHIO

Washington

Washington

Washington

Washington, D.C.

Ohio

Washington

Washington, D.C.

Washington County

March 1, 1909

Shirley

Ohio

Phillip

March 31, 1909

White

Male

Washington, D.C.

Shirley Ann

Shirley Ann

Shirley Ann, 1909

*Shirley Ann*

*Shirley Ann*

Shirley Ann

Shirley Ann, 1909

Shirley Ann, 1909

2 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |  |  |  |  |  |   |  |   |  |  |  |                  |  |                            |  |  |  |          |  |  |  |
|--|--|--|--|--|--|--|--|---|--|---|--|--|--|------------------|--|----------------------------|--|--|--|----------|--|--|--|
| 06088  |  |  |  |  |  |  |  |   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  |  |  |                  |  |                            |  |  |  | 06084    |  |  |  |
| 1. DECEASED-NAME (Type or print)   |  |  |  |  |  |  |  |   |  | 2a. DATE OF DEATH   |  |  |  |                  |  |                            |  |  |  | 2b. HOUR |  |  |  |
| First Middle Last  |  |  |  |  |  |  |  |   |  | Month Day Year  |  |  |  |                  |  |                            |  |  |  |          |  |  |  |
| Mary Ellen Souders   |  |  |  |  |  |  |  |   |  | April 28, 1989  |  |  |  |                  |  |                            |  |  |  | 12:15P M |  |  |  |
| 3. SEX   |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH   |  |   | 6. AGE (In years lost birthday)  |   |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS. |  |                            |  |  |  |          |  |  |  |
| Female   |  |  | White  |  |  | July 30, 1888  |  |   | 80 YRS.  |   |  | MONTHS DAYS  |  | HOURS MIN.       |  |                            |  |  |  |          |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH   |   |  |  |  |                  |  | Md.                        |  |  |  |          |  |  |  |
| McConnellsburg, Pa.  |  |  | U. S. A.   |  |  |  |  |   | Washington   |   |  |  |  |                  |  |                            |  |  |  |          |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |  |  |                  |  |                            |  |  |  |          |  |  |  |
| Hagerstown   |  |  | Washington Co., Hospital   |  |  | Housewife  |  |   | Own Home   |   |  |  |  |                  |  |                            |  |  |  |          |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN  |  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  | 13e. STREET AND NUMBER   |  |                  |  |                            |  |  |  |          |  |  |  |
| Maryland   |  |  | Washington   |  |  | Boonsboro  |  |   |  |   |  | Rfd. 2   |  |                  |  |                            |  |  |  |          |  |  |  |
| 14. FATHER'S NAME First Middle Last  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last |  |  |   |  |   |  |  |  |                  |  |                            |  |  |  |          |  |  |  |
| William Shaw   |  |  |  |  | Emma Kuhn                                  |  |  |   |  |   |  |  |  |                  |  |                            |  |  |  |          |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)   |  |  |  |  | 16b. SOCIAL SECURITY NO.                   |  |  |   |  | 17. INFORMANT Address   |  |  |  |                  |  |                            |  |  |  |          |  |  |  |
| No.  |  |  |  |  | 219-20-1651                                |  |  |   |  | Mr. William Souders, Rfd. 2, Boonsboro, Md.                                 |  |  |  |                  |  |                            |  |  |  |          |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                |  |  |  |                  |  |                            |  |  |  |          |  |  |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |   |  |   |  |  |  |                  |  |                            |  |  |  |          |  |  |  |
| IMMEDIATE CAUSE (a) Adenocarcinoma of colon with metastases  |  |  |  |  |  |  |  |   |  | 2 years   |  |  |  |                  |  |                            |  |  |  |          |  |  |  |
| 1538 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |   |  |   |  |  |  |                  |  |                            |  |  |  |          |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |  |  |  |  |  |  |   |  | (b) DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |                  |  |                            |  |  |  |          |  |  |  |
|  |  |  |  |  |  |  |  |   |  | (c)   |  |  |  |                  |  |                            |  |  |  |          |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |   |  |   |  |  |  |                  |  |                            |  |  |  |          |  |  |  |
| Diabetes mellitus.   |  |  |  |  |  |  |  |   |  |   |  |  |  |                  |  |                            |  |  |  |          |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                  |  |                            |  |  |  |          |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |                  |  |                            |  |  |  |          |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |                  |  |                            |  |  |  |          |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-2, 19 57, to 4-26, 19 69, that (I) (we) last saw the deceased alive on 4-26 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |   |  |  |  |                  |  |                            |  |  |  |          |  |  |  |
| 22b. SIGNATURE Charles F. Hess M.D. DEGREE   |  |  |  |  |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED 4-28-69   |  |                  |  |                            |  |  |  |          |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) Charles F. Hess, M.D.   |  |  |  |  |  |  |  | 22e. ADDRESS Smithsburg, Maryland 21783   |  |   |  |  |  |                  |  |                            |  |  |  |          |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  | 23b. DATE  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |   |  | 23d. LOCATION (City or Town) (County) (State)                        |  |                  |  |                            |  |  |  |          |  |  |  |
| Burial   |  |  |  | 4-29-69  |  |  |  | Mt. Lena Cemetery   |  |   |  | Mt. Lena, Wash. Co., Md.   |  |                  |  |                            |  |  |  |          |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |  |  | ADDRESS   |  |   |  | 25a. REC'D BY REGISTRAR  |  |                  |  | 25b. REGISTRAR'S SIGNATURE |  |  |  |          |  |  |  |
| John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.   |  |  |  |  |  |  |  |   |  |   |  | MAY 1 1969   |  |                  |  | Charles Judge              |  |  |  |          |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |   |   |   |                                |  |
|--|--|--|--|---|---|---|---|--------------------------------|--|
| 06089 CERTIFICATE OF DEATH 06085   |  |  |  |   |   |   |   |                                |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |   |   | 2a. DATE OF DEATH   |   |                                | 2b. HOUR                                     |
| Hattie Isabelle Spangler   |  |  |  |   |   | Month Day Year<br>April 8 1969  |   |                                | 10:45 PM                                     |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)   |   | IF UNDER 1 YEAR<br>MONTHS DAYS |  |
| Female   |  | White  |  | Feb. 5, 1893  |   | 76 YRS.   |   |                                |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |   |                                |  |
| Penna.   |  | U.S.A.   |  |   |   | Washington Md.  |   |                                |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   |                                | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Hagerstown   |  |  | Washington Co. Hospital  |   |   | Housewife   |   |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |                                | 13e. STREET AND NUMBER                       |
| Penna.   |  |  | Franklin   |   | Waynesboro  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                | R. D. 4                                      |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |   |   |   |   |                                |  |
| First Middle Last  |  |  | First Middle Last  |   |   |   |   |                                |  |
| Upton Ward   |  |  | Annie Musselman  |   |   |   |   |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address   |   |   |                                |  |
| no   |  |  | 187-16-5335  |   | Mr. Joseph E. Spangler Waynesboro R.D. 4, Pa.                       |   |   |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |   |   |   |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |   |   |   |   |                                | 5 day  |
| IMMEDIATE CAUSE (a) Myocardial infarction  |  |  |  |   |   |   |   |                                |  |
| 2509 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |   |   |   |                                |  |
| (b) Atherosclerotic heart disease  |  |  |  |   |   |   |   |                                |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |   |   |   |                                |  |
| (c) Diabetes Mellitus  |  |  |  |   |   |   |   |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |   |   |   |                                |  |
| Uremia 2° to Chronic Renal Disease & Fractured Pelvis.   |  |  |  |   |   |   |   |                                |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                                |  |
|  |  |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |                                |  |
| 21a. ACCIDENT WAS UNDERLYING   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |   |   |   |                                |  |
| <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | HOUR A.M. Month Day Year<br>P.M. 19  |  |   |   |   |   |                                |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |   |                                |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  |  |   |   |   |   |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/29/67, 19, to 4/11/69, 19, that (I) (we) last saw the deceased alive on 4/11/69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |   |                                |  |
| 22b. SIGNATURE   |  |  |  |   | DEGREE  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                | 22c. DATE SIGNED                             |
| William O. Rexrode, M.D.   |  |  |  |   |   |   |   |                                | 4/9/69                                       |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |   | 22e. ADDRESS  |   |   |                                |  |
|  |  |  |  |   | 145 S. Prospect St Hagerstown, Md.                                  |   |   |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   |   | 23d. LOCATION (City or Town) (County) (State)   |                                |  |
| Burial   |  | 4/11/1969  |  | Green Hill  |   |   | Waynesboro, Franklin, Pa.   |                                |  |
| 24. FUNERAL DIRECTOR   |  |  |  |   | ADDRESS   |   | 25a. REC'D BY REGISTRAR   |                                | 25b. REGISTRAR'S SIGNATURE                   |
| H. G. G. G. G.   |  |  |  |   | Waynesboro, Penna.  |   | DATE APR 14 1969  |                                | J. J. J. J.                                  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

06086

06090

|   |  |   |                          |   |  |   |   |   |                                |        |   |
|---|--|---|--------------------------|---|--|---|---|---|--------------------------------|--------|---|
| 1. DECEASED-NAME<br>(Type or print)   |  |   | First                    | Middle  | Last   | 2a. DATE OF DEATH<br>Month Day Year   |   |   | 2b. HOUR                       |        |   |
| Charles Beckley Stine   |  |   |                          |   |  | April 7, 1969   |   |   | 5:00P M                        |        |   |
| 3. SEX  |  | 4. RACE   |                          | 5. DATE OF BIRTH  |  |   | 6. AGE (In years<br>lost birthday)            |   | IF UNDER 1 YEAR<br>MONTHS DAYS |        |   |
| Male  |  | White   |                          | March 27, 1875  |  |   | 94 YRS.                                       |   |                                |        |   |
| 7a. BIRTHPLACE (State or foreign<br>country)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH                            |   | Md                             |        |   |
| Locust Grove, Md.   |  | U. S. A.  |                          |   |  |   | Washington                                    |   |                                |        |   |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |                          |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                    |                                |        |   |
| Rohrersville  |  | Rfd. 1  |                          |   | Labor  |   |   | State Roads Dept  |                                |        |   |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE  |  | 13b. COUNTY   |                          | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 13e. STREET AND NUMBER  |                                |        |   |
| Maryland  |  | Washington  |                          | Rohrersville  |  |   |   | Rfd. 1  |                                |        |   |
| 14. FATHER'S NAME   |  |   | First                    | Middle  | Last   | 15. MOTHER'S MAIDEN NAME  |   |   | First                          | Middle | Last  |
| Lawson  |  |   |                          |   | Stine  | Anna  |   |   |                                |        | Lumbach   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |  |   | 16b. SOCIAL SECURITY NO. |   |  | 17. INFORMANT   |   |   |                                |        |   |
| No.   |  |   | 220-10-3937              |   |  | Mrs. M. Mae Horine, Rfd. 1, Rohrersville, Md.   |   |   |                                |        |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Seizure with Generalized arteriosclerosis</u><br>4409 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |                          |   |  |   |   |   |                                |        | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Seizure</u>  |  |   |                          |   |  |   |   |   |                                |        |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |                          |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |                                |        |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |   |                                |        |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |                          | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |   |                                |        |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/27</u> , 19 <u>68</u> , to <u>4/7</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/4</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                 |  |   |                          |   |  |   |   |   |                                |        |   |
| 22b. SIGNATURE<br><u>R. Amarillo</u>  |  |   |                          |   |  | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><u>4/8/69</u>                                       |                                |        |   |
| 22d. PHYSICIAN'S NAME (Type)<br><u>R. Amarillo</u>  |  |   |                          |   |  | 22e. ADDRESS<br><u>Sharpsburg, Md 21782</u>   |   |   |                                |        |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |  | 23b. DATE   |                          | 23c. NAME OF CEMETERY OR CREMATORY  |  |   | 23d. LOCATION (City or Town) (County) (State) |   |                                |        |   |
| Burial  |  | 4- 10- 69   |                          | Locust Grove Cemetery   |  |   | Locust Grove, Wash. Co., Md.                  |   |                                |        |   |
| 24. FUNERAL DIRECTOR<br>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md   |  |   |                          |   |  | 25a. REC'D BY REGISTRAR<br>APR 10 1969  |   | 25b. REGISTRAR'S SIGNATURE<br><u>W. Charles Judge</u>                   |                                |        |   |

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Charles H. Hoxley  
June 7, 1937

John H. Hoxley  
June 27, 1937

Robert H. Hoxley  
June 27, 1937

John H. Hoxley  
June 27, 1937

Robert H. Hoxley  
June 27, 1937

John H. Hoxley  
June 27, 1937

John H. Hoxley  
June 27, 1937

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| 06091 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |         |                              |  |  |  |   |  |   |   | 06087  |  |
|---|---------|------------------------------|--|--|--|---|--|---|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |         |                              |  |  |  |   |  |   |   |  |  |
| 1. DECEASED-NAME<br>(Type or Print)   |         |                              | First Middle Last  |  |  | 2a. DATE KNOWN OF DEATH   |  |   | 2b. HOUR  |  |  |
| OTHER T. STOTLER  |         |                              |  |  |  | Month Day Year  |  |   | 8:15 P.M.   |  |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (In years lost birthday)  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD  |   | 2d. HOUR                                     |  |
| MALE  | WHITE   | OCT 29 1912                  | 56 YRS   | MONTHS DAYS  |  | HOURS MIN.  |  | Month Day Year  | 8:15 P.M.   |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED   |  | NEVER MARRIED   |  | 9. COUNTY OF DEATH  |   | MD.  |  |
| W.VA.   |         | USA                          |  | WIDOWED  |  | DIVORCED  |  | WASHINGTON  |   |  |  |
| 10. CITY OR TOWN OF DEATH   |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |
| HAGERSTOWN  |         |                              | WASHINGTON Co.   |  |  | LABORER   |  |   | FARM  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |                              | 13b. COUNTY  |  |  | 13c. CITY OR TOWN   |  |   | 13d. INSIDE CITY LIMITS?  |  |  |
| W.VA.   |         |                              | MORGAN   |  |  | BERKELEY SPRINGS  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME   |         |                              | 15. MOTHER'S MAIDEN NAME   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |  |   | 16b. SOCIAL SECURITY NO.  |  |  |
| ROBERT W. STOTLER   |         |                              | SARAH E. STOTLER   |  |  | NO  |  |   | —   |  |  |
| 17. INFORMANT   |         |                              | 17. ADDRESS  |  |  | 17. ADDRESS   |  |   | 17. ADDRESS   |  |  |
| Mrs. Ramsey Mason   |         |                              | BERKELEY SPRINGS, W.Va.  |  |  |   |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |                              |  |  |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:  |         |                              |  |  |  |   |  |   |   |  |  |
| IMMEDIATE CAUSE (a) Severe Laceration Left Frontal-   |         |                              |  |  |  |   |  |   |   |  |  |
| 955X DUE TO, OR AS A CONSEQUENCE OF   |         |                              |  |  |  |   |  |   |   |  |  |
| (b) Parietal + Occipital lobes - Massive  |         |                              |  |  |  |   |  |   |   | 6 days                                       |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |                              |  |  |  |   |  |   |   |  |  |
| (c) Subdural + epidural Hemorrhage  |         |                              |  |  |  |   |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |         |                              |  |  |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |         |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |  |   |  | 20. AUTOPSY?  |   |  |  |
| 3/31/69   |         |                              |  | gunshot wound of Head  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                        |   |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>   |         |                              |  | 21b. TIME OF INJURY Month, Day, Year   |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |  |  |
| CAUSE OF DEATH  |         |                              |  | 3:30 P.M. 3/27/1969  |  |   |  | Self inflicted gunshot wound of Head  |   |  |  |
| 21d. INJURY OCCURRED  |         |                              |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |   |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |         |                              |  | Farm   |  |   |  | Rt #522 15th S. Berkeley Springs W.Va.  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |                              |  |  |  |   |  |   |   |  |  |
| ACTUAL SIGNATURE  |         |                              |  | CHIEF MEDICAL EXAMINER   |  |   |  | 22b. DATE SIGNED  |   |  |  |
| Edward W. Ditto, III  |         |                              |  | M.D.   |  |   |  | 4-2-69  |   |  |  |
| EXAMINER'S NAME (Type)  |         |                              |  | DEPUTY MEDICAL EXAMINER  |  |   |  | 217 W. WASHINGTON ST.   |   |  |  |
| EDWARD W. DITTO, III, M.D.  |         |                              |  | ADDRESS (Street, city, town, or county)                                      |  |   |  | HAGERSTOWN, MARYLAND  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         |                              |  | 23b. DATE  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY  |   |  |  |
| Burial  |         |                              |  | 4-4-69   |  |   |  | OAKLAND   |   |  |  |
| 24. FUNERAL DIRECTOR  |         |                              |  | 25a. REC'D BY REGISTRAR  |  |   |  | 25b. REGISTRAR'S SIGNATURE  |   |  |  |
| James H. Hunter   |         |                              |  | DATE APR 7 1969  |  |   |  | Charles Judge   |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-64  
45M - 11-64

|   |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|
| 06092   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  | 06088  |  |  |  |
| 1. DECEASED-NAME (Type or print)  |  |  |  |  |  | 2a. DATE OF DEATH  |  | 2b. HOUR                                     |  |
| ANNA MARY LAVINIA STOUFFER  |  |  |  |  |  | April 14 1969  |  | 9220 M                                       |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years lost birthday)  |  | IF UNDER 1 YEAR                              |  |
| Female  |  | White  |  | November 11 1891   |  | 77 YRS.  |  | MONTHS DAYS HOURS MIN                        |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |  |  |
| Penna   |  | USA  |  |  |  | Washington Md.   |  |  |  |
| 1d. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| Hagerstown  |  | Wash. Co Hospital  |  | Knitting Mill  |  | --   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                       |  |
| Maryland  |  | Washington   |  | Hagerstown   |  |  |  | 304 Nottingham Rd.                           |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |
| Samuel Lake   |  | Sarah Metcalf  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address  |  |  |  |  |  |
| No  |  | 213-10-6866  |  | Frank C Stouffer 304 Nottingham Rd   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u>  |  |  |  |  |  |  |  |  |  |
| 4123 DUE TO, OR AS A CONSEQUENCE OF <u>Cardiac Failure</u>  |  |  |  |  |  |  |  | 1 yr   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/2/69, 19__, to 4/14/69, 19__, that (I) (we) last saw the deceased alive on 4/14/69, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED   |  |  |  |  |  |  |  |
| Robert H. Campbell  |  | 4/15/69  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |
| Robert H. Campbell  |  | HAGERSTOWN MD  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |
| Burial  |  | 4/16/69  |  | Cedar Lawn Mem.  |  | Gardens Hagerstown Wash Co Md  |  |  |  |
| 24. FUNERAL DIRECTOR  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |
| Andrew K. Coffman   |  | APR 21 1969  |  | James Judge  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |      |   |  |  |   |
|--|--|--|--|---|------|---|--|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |      |   |  |  |   |
| CERTIFICATE OF DEATH   |  |  |  |   |      |   |  |  |   |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First  | Middle  | Last | 2a. DATE OF DEATH   |  |  | 2b. HOUR  |
| KATIE VIOLA STOUFFER   |  |  |  |   |      | APRIL Month 26 Day 1969 Year  |  |  | 2 P.M.  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |      | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN   |   |
| FEMALE   |  | WHITE  |  | 12/1/1884   |      | 84 YRS.   |  |  |   |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9. COUNTY OF DEATH  |  |  |   |
| MARYLAND   |  | U.S.A.   |  |   |      | WASHINGTON Md.  |  |  |   |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| HAGERSTOWN   |  |  | WASHINGTON CO. HOSPITAL  |   |      | HOUSEWIFE   |  | HOME   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |   |      | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| MARYLAND   |  |  | WASHINGTON   |   |      | HAGERSTOWN  |  | RT. #3   |   |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |   |      |   |  |  |   |
| First Middle Last  |  |  | First Middle Last  |   |      |   |  |  |   |
| JOHN BEITLER   |  |  | LYDIA KAYHOE   |   |      |   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |   |      | 17. INFORMANT Address   |  |  |   |
| NO   |  |  | 213-48-5287  |   |      | MR. CHARLES S. STOUFFER MD. HAGERSTOWN  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardio vascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>General arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u>  |  |  |  |   |      |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>10 years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |      |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |      |   |  |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |      |   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-1-</u> , 19 <u>69</u> , to <u>4-26-</u> , 19 <u>69</u> , that (I) (we) lost the deceased alive on <u>4-23-</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |      |   |  |  |   |
| 22b. SIGNATURE   |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |   |      | 22c. DATE SIGNED  |  |  |   |
| <i>E. W. Ditto</i>   |  |  |  |   |      | 4-28-69   |  |  |   |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS   |  |   |      |   |  |  |   |
| Dr. E. W. Ditto, Jr.   |  | 215 W. Washington ST., Hagerstown, Md.   |  |   |      |   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |      | 23d. LOCATION (City or Town) (County) (State)   |  |  |   |
| BURIAL   |  | 4/29/69  |  | SMITHSBURG CEM.   |      | SMITHSBURG WASH. MD.  |  |  |   |
| 24. FUNERAL DIRECTOR   |  | 25a. REC'D BY REGISTRAR  |  |   |      | 25b. REGISTRAR'S SIGNATURE  |  |  |   |
| <i>W. J. Norment, Hagerstown, Md.</i>  |  | MAY 5 1969   |  |   |      | <i>Charles Judge</i>  |  |  |   |



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RECEIVED  
DEPT. OF THE ARMY  
WASHINGTON, D.C.

DATE: 10/10/50  
TO: THE SECRETARY OF THE ARMY  
FROM: THE SECRETARY OF THE ARMY

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4-69)  
45M - 1-69

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 06094   |  | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  |   |  | 06090   |  |
| 1. DECEASED-NAME<br>(Type or print) <b>Reichard Milton Stover</b>   |  |  |  | 2a. DATE OF DEATH<br><b>April</b> Month <b>11</b> Day <b>1969</b> Year  |  | 2b. HOUR<br><b>1:18A</b> M  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>March 31, 1898</b>   |  | 6. AGE (In years last birthday)<br><b>71</b> YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Washington</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Hagerstown</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Washington County Hospital</b>  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Maintenance Man</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Tannery</b>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. CITY OR TOWN<br><b>Washington</b>   |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>R.F.D. #1</b>   |  | 13d. STREET AND NUMBER  |  |
| 14. FATHER'S NAME<br>First <b>Albertus</b> Middle <b>Stover</b> Last <b>Stover</b>  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Martha</b> Middle <b>Danner</b> Last <b>Danner</b>                            |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, name unknown <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><b>213-10-6896</b>   |  | 17. INFORMANT<br>Address <b>Mrs. Frances Stover Williamsport, Md. RFD #1</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Atherosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Hypertensive Cardiovascular Disease</b> |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7 days</b><br><b>13 years</b><br><b>13 years</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Extensive Pulmonary Emphysema; Chronic Bronchitis; Bronchial Asthma; Tb both kidneys</b>   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>                     |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                       |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Mar 31</b> , 19 <b>69</b> , to <b>Apr 11</b> , 19 <b>69</b> , that (I) <del>two</del> last saw the deceased alive on <b>Apr 11</b> , 19 <b>69</b> , and that in (my) <del>her</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>we</del> <del>(did)</del> <del>(did not)</del> view the body after death.                    |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>W. T. Layman, M.D.</b>   |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  | 22c. DATE SIGNED<br><b>Apr 11 69</b>  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>William T. Layman, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>301 E. Antietam St. Hagerstown, Md. 21740</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Type)<br><b>Burial</b>   |  | 23b. DATE<br><b>April 13, 1969</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Manor Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Tilghmanton, Washington, Md.</b>                |  |
| 24. FUNERAL DIRECTOR<br><b>Albert L. Leaf Williamsport, Md.</b>   |  |  |  | 25a. REG. BY REGISTRAR<br><b>APR 15 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. C. Judge</b>  |  |

00000

STATE OF TEXAS

County of \_\_\_\_\_

City of \_\_\_\_\_

State of \_\_\_\_\_

1900

March 11, 1900

Witness my hand and seal of office

Notary Public in and for the State of Texas

My commission expires \_\_\_\_\_

Attest my hand and seal of office

Notary Public in and for the State of Texas

My commission expires \_\_\_\_\_

Witness my hand and seal of office

Notary Public in and for the State of Texas

My commission expires \_\_\_\_\_

Witness my hand and seal of office

Notary Public in and for the State of Texas

My commission expires \_\_\_\_\_

Witness my hand and seal of office

Notary Public in and for the State of Texas

My commission expires \_\_\_\_\_

Witness my hand and seal of office

Notary Public in and for the State of Texas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |   |   |               |   |                                       |   |  |
|--|--|---|---|---|---------------|---|---------------------------------------|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |   |   |               |   |                                       |   |  |
| CERTIFICATE OF DEATH   |  |   |   |   |               |   |                                       |   |  |
| 06095  |  |   |   |   |               |   |                                       |   |  |
| 061191   |  |   |   |   |               |   |                                       |   |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |   | First   | Middle  | Last          | 2a. DATE OF DEATH<br>Month Day Year   |                                       |   | 2b. HOUR   |
| IRA CLINTON STRITE   |  |   |   |   |               | April 27, 1969  |                                       |   | 8:30 P.M.  |
| 3. SEX   |  | 4. RACE   |   | 5. DATE OF BIRTH  |               | 6. AGE (In years<br>last birthday)  |                                       | IF UNDER 1 YEAR<br>MONTHS DAYS  |  |
| Male   |  | white   |   | 1/9/1896  |               | 73 YRS.   |                                       |   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |               | 9. COUNTY OF DEATH  |                                       |   | Md.  |
| Wash. Co., Md.   |  | U.S.A.  |   |   |               | Washington  |                                       |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |               | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |                                       |   |  |
| Hagerstown   |  | Wash. Co. Hospital  |   | Farmer  |               | FARM  |                                       |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission)   |  | 13b. COUNTY   |   | 13c. CITY OR TOWN   |               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                       | 13e. STREET AND NUMBER  |  |
| Maryland   |  | Wash.   |   | Hagerstown  |               |   |                                       | 2436 Paradise Drive   |  |
| 14. FATHER'S NAME  |  |   | First   | Middle  | Last          | 15. MOTHER'S MAIDEN NAME  |                                       |   | First Middle Last  |
| Franklin M. Strite   |  |   |   |   |               | Lydia Horst Strite  |                                       |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |  |   | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service) |   | 17. INFORMANT |   | 2436 Paradise Drive<br>Hagerstown Md. |   |  |
| No   |  |   | 215-36-7025   |   | Cora Strite   |   |                                       |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest due to ventricular</u><br><u>4123</u> DUE TO, OR AS A CONSEQUENCE OF <u>fibrillation</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiac disease</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>Several years</u><br>(c) |  |   |   |   |               |   |                                       |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>Instant |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |   |   |               |   |                                       |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |   |               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                       | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |
|  |  |   |   |   |               |   |                                       |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |               |   |                                       |   |  |
|  |  |   |   |   |               |   |                                       |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No.  |               | City or Town  |                                       | County State  |  |
|  |  |   |   |   |               |   |                                       |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-11-</u> , 19 <u>69</u> , to <u>4-27-</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4-27-</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |               |   |                                       |   |  |
| 22b. SIGNATURE<br><u>E. W. Dittus, Jr.</u>   |  | DEGREE  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |               | 22c. DATE-SIGNED<br><u>4/28/1969</u>  |                                       |   |  |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS  |   |   |               |   |                                       |   |  |
| E. W. Dittus, Jr.  |  | 215 W. Wash. St. - Hagerstown, Md.  |   |   |               |   |                                       |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY  |               | 23d. LOCATION (City or Town) (County) (State)   |                                       |   |  |
| Burial   |  | 4/30/69   |   | Reiff Church Cem.   |               | Cearfosa, Md.   |                                       |   |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS   |   | 25a. APPROVED BY REGISTRAR<br>DATE  |               | 25b. REGISTRAR'S SIGNATURE  |                                       |   |  |
| A. E. Minnich - Greencastle, Pa.   |  |   |   | APR 30 1969   |               | [Signature]   |                                       |   |  |

72020

TABLE 1. 1960-1961

1. 1960-1961

2. 1960-1961

3. 1960-1961

4. 1960-1961

5. 1960-1961

6. 1960-1961

7. 1960-1961

8. 1960-1961

9. 1960-1961

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11. 1960-1961

12. 1960-1961

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15. 1960-1961

16. 1960-1961

17. 1960-1961

18. 1960-1961

19. 1960-1961

20. 1960-1961

21. 1960-1961

22. 1960-1961

23. 1960-1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

06096

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06092

|   |  |  |  |  |  |  |   |   |     |
|---|--|--|--|--|--|--|---|---|-----|
| 1. DECEASED-NAME<br>(Type or print)<br><b>Fannie Cecelia Thomas</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>April</b> Day <b>8</b> , Year <b>1969</b>                  |  |  | 2b. HOUR<br><b>10:00 P M</b>   |   |   |     |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>August 3, 1897</b>  |  | 6. AGE (In years last birthday)<br><b>71</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS<br>IF UNDER 24 HRS.<br>HOURS MIN. |     |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Sharpsburg, Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Washington</b>  |   |   | Md. |
| 10. CITY OR TOWN OF DEATH<br><b>Hagerstown</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Washington Co. Hospital</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housekeeper</b>                          |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>        |     |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Washington</b>   |  | 13c. CITY OR TOWN<br><b>Keedysville</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>Rfd. 1</b>                     |     |
| 14. FATHER'S NAME<br>First <b>Silas</b> Middle <b>Thomas</b> Last <b>Thomas</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Susan</b> Middle <b>Hammond</b> Last <b>Hammond</b> |  |  |  |   |   |     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No.</b> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><b>220-52-2125</b>   |  | 17. INFORMANT<br>Address <b>Mrs. Juanita Netz, Rfd. 1, Keedysville, Md.</b>  |  |  |   |   |     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary embolus</b><br><b>398X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arterial fibrillation</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>Rheumatic &amp; arteriosclerotic heart disease 7 years</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 1/2 weeks</b> |  |  |  |  |  |  |   |   |     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |   |   |     |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>     |   |     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |   |     |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                   |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |   |     |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-9-</b> , 19 <b>69</b> , to <b>4-8-</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>4-8-</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |   |   |     |
| 22b. SIGNATURE <b>Joseph Secondary</b>  |  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4-10-69</b>  |   |     |
| 22d. PHYSICIAN'S NAME (Type) <b>JOSEPH SECONDARY</b>  |  |  |  |  | 22e. ADDRESS <b>Boonsboro Md</b>   |  |   |   |     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>4-11-69</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bakersville Cemetery</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Bakersville, Wash. Co., Md.</b> |   |     |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>  |  |  |  |  | 25a. REC'D BY REGISTRAR<br><b>APR 14 1969</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                  |   |     |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15 (4)  
30M REV. 7-68

06097

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06093

|   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |
|---|--|--|--|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>ATHENA</b>   |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH<br>Month Day Year <b>4 21 69</b>  |  |  | 2b. HOUR<br><b>3:45</b> AM  |  |  |   |  |  |
| 3. SEX<br><b>FEMALE</b>   |  |  | 4. RACE<br><b>WHITE</b>  |  |  | 5. DATE OF BIRTH<br><b>MARCH 6, 1891</b>  |  |  | 6. AGE (In years lost birthday)<br><b>78</b> YRS.   |  |  |   |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>TURKEY</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>WASHINGTON</b> Md.   |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>HAGERSTOWN</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>WASH. CO. HOSP.</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>COOK</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>RESTAURANT</b>   |  |  |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD.</b>   |  |  | 13b. COUNTY<br><b>WASHINGTON</b>   |  |  | 13c. CITY OR TOWN<br><b>HAGERSTOWN</b>  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |  |  | 13e. STREET AND NUMBER<br><b>1037 PENNA. AVE.</b>     |  |  |
| 14. FATHER'S NAME<br><b>JAMES</b>   |  |  | First Middle Last  |  |  | 15. MOTHER'S MAIDEN NAME<br><b>SHARKEY</b>  |  |  | First Middle Last   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>NO</b>  |  |  | (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.<br><b>218-30-9191-B</b>  |  |  | 17. INFORMANT<br><b>JOHN TRANTOULES</b>   |  |  | Address<br><b>1037 PA. AVE. HAGERSTOWN, MD.</b>       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arterio Sclerosis heart disease</b><br><b>4123</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>year</b> |  |  |  |  |  |   |  |  |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Obesity</b>   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                      |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                           |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |   |  |  |
| 22a. I certify that (I) (his hospital) attended the deceased from <b>Jan</b> , 19 <b>60</b> , to <b>4/21</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>16 April</b> 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Eldon G. Hoachlander</b>   |  |  |  |  |  | DEGREE<br><b>MD.</b>  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>APRIL 21, 1969</b>             |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>ELDON G. HOACHLANDER, M.D.</b>   |  |  |  |  |  | 22e. ADDRESS<br><b>115 WEST WASHINGTON STREET</b>   |  |  |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>4-23-1969</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ROSE HILL CEMETERY</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>HAGERSTOWN WASHINGTON MD.</b>   |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Charles M. Reuser</b>  |  |  |  |  |  | ADDRESS<br><b>HAGERSTOWN, MD.</b>   |  |  | 25a. REC'D BY REGISTRAR<br><b>APR 23 1969</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>William J. Indel</b> |  |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 06098  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |  | 06094  |  |  |  |  |  |  |  |  |  |
| Item 13 Film 412 5/1/69 kk   |  |  |  |  |  |  |  |  |  | CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>CELIA FLORENCE TURNER  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH Month Day Year<br>April 23 1969   |  |  |  |  |  |  |  |  |  | 2b. HOUR A M<br>9.30 M   |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>Female   |  |  |  |  | 4. RACE<br>White   |  |  |  |  | 5. DATE OF BIRTH<br>July 17 1899  |  |  |  |  | 6. AGE (In years last birthday)<br>69 YRS.   |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN      |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH<br>Washington Md.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Hagerstown  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Wash County Hospital |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)<br>Housewife   |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |  |  |  |  | 13b. COUNTY<br>Washington  |  |  |  |  | 13c. CITY OR TOWN<br>Hagerstown   |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER<br>R.F.D. #3<br>Clear View Nursing Home |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>Angle Daley   |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Rachael Myers  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No  |  |  |  |  | 16b. SOCIAL SECURITY NO. N one   |  |  |  |  | 17. INFORMANT Address<br>Norman Turner Weaver Ave   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) 4100 Massive Pulmonary Embolist<br>DUE TO, OR AS A CONSEQUENCE OF (b) Auricular Fibrillation<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Hypertensive Cardiovascular Disease with recent mural<br>DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Hrt. Disease;<br>(c) Hypertensive Cardiovascular Disease with recent mural |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>15 mins<br>Periodic several yrs<br>5 yrs. certain   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) thrombosis left<br>Gangrene 5th toe; Nephrosclerosis; Chr. Colecystitis & Cholelithiasis. auricle  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year<br>P.M. 19  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                         |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 16, 1969, to April 23, 1969, that (I) (we) last saw the deceased alive on April 22, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>W. T. Layman   |  |  |  |  |  |  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED<br>April 24 1969                              |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>William T. Layman, M.D.  |  |  |  |  | 22e. ADDRESS<br>301 E. Antietam St. Hagerstown, Md   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  |  |  |  | 23b. DATE<br>4/26/69   |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Pleasant Hill U.B. Cem.   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Ceseytown Franklin Co Pa                    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Andrew K. Coffman  |  |  |  |  | Hagerstown Md ADDRESS<br>Funeral Home Inc  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE APR 28 1969   |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 06095  
**CERTIFICATE OF DEATH**

|   |   |   |  |   |  |
|---|---|---|--|---|--|
| 1. DECEASED-NAME (Type or print)<br><b>WALTER EUGENE TURNER</b>   |   |   | 2a. DATE OF DEATH<br><b>APRIL</b> Month Day <b>16</b> Year <b>69</b>                         |   | 2b. HOUR<br>M  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br><b>Aug. 25, 1913</b>  |  | 6. AGE (In years lost birthday)<br><b>55</b> YRS.                               | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Washington</b> Md.                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Hagerstown</b>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Washington County Hospital</b> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>File Clerk</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>   | 13b. COUNTY <b>Washington</b>   | 13c. CITY OR TOWN <b>Williamsport</b>   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER<br><b>129 S. Vermont St.</b>                             |  |
| 14. FATHER'S NAME First Middle Last<br><b>James Elmer Turner</b>  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Olive Gerakline Turner</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>II</b>  |   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT Address<br><b>Phyllis F. Boners Turner 129 S. Vermont St.</b>     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br><b>4109</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary thrombosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary arteriosclerosis</b> |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |   | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |   | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-16</b> , 19 <b>69</b> , to <b>4-19</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Howard F. Grove</b>  |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                      |  | 22c. DATE SIGNED<br><b>4-17-69</b>  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>HOWARD F. GROVE</b>  |   | 22e. ADDRESS<br><b>580 Hawthorne Ave. Hagerstown</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |   | 23b. DATE<br><b>4-19-69</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenlawn</b>                          |  |
| 24. FUNERAL DIRECTOR<br><b>Howard F. Grove</b>  |   | ADDRESS<br><b>Williamsport Md.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>APR 21 1969</b>                                   |  |
|   |   |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                              |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
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| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 06100  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 1. PLACE OF DEATH<br>e. COUNTY <b>Washington</b> <b>MARYLAND</b>   |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>e. STATE <b>W. Va.</b> <b>Morgan</b> COUNTY |  |  |  |  |   |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |  |  |  |  | c. LENGTH OF STAY IN 1b<br><b>7 Das.</b>   |  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Great Cacapon, W. Va.</b>                              |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Washington County Hospital</b>  |  |  |  |  | d. STREET ADDRESS<br><b>c/o Postmaster</b>   |  |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>David Ryan Twigg</b>  |  |  |  |  | 4. DATE OF DEATH<br><b>April 28, 19 69</b>   |  |  |  |  |   |  |  |  |  |
| 5. SEX<br><b>Male</b>  |  |  |  |  | 6. COLOR OR RACE<br><b>White</b>   |  |  |  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |
| 8. DATE OF BIRTH<br><b>April 20, 1969</b>  |  |  |  |  | 9. AGE (in years last birthday)<br><b>7 yrs.</b>   |  |  |  |  | 10. IF UNDER 1 YEAR<br>Months <b>7</b> Days <b>7</b> Hours <b>7</b> Min.  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Infant</b>   |  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>  |  |  |  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Hagerstown, Md.</b>   |  |  |  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |  | 13. FATHER'S NAME<br><b>Robert L. Twigg</b>  |  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Christina Spring</b>   |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>Infant</b>  |  |  |  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  |  |  |  | 17. INFORMANT<br><b>Robert L. Twigg, Great Cacapon, W. Va.</b>  |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br><b>7762</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Prematurity</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br><b>None</b> |  |  |  |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b><br><b>Since birth</b>  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  |  |  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  |  |  |  |  |  |  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                                     |  |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |  |  |  |  |  |  |  |  | 20f. (City or town) (County) (State)  |  |  |  |  |
| 21. I certify that (I) ( <del>his hospital</del> ) attended the deceased from <b>4-20</b> <b>1969</b> , to <b>4-28</b> <b>1969</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>4-27</b> <b>1969</b> , and that death occurred at <b>7:55 AM</b> , from the causes and on the date stated above.   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 22a. SIGNATURE<br><b>E. Margaret Sullivan M.D.</b>   |  |  |  |  |  |  |  |  |  | 22b. DATE SIGNED<br><b>4-29-69</b>  |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>E. Margaret Sullivan M.D.</b>   |  |  |  |  |  |  |  |  |  | 22d. ADDRESS<br><b>1610 X Oak Hill Ave.<br/>Hagerstown, Maryland</b>  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  |  |  |  |  |  |  |  | 23b. DATE THEREOF<br><b>4/28/1969</b>   |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Great Cacapon Cemetery</b>  |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City, town or county) (State)<br><b>Great Cacapon, W. Va.</b>  |  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Berkeley Springs, W. Va.</b>  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br><b>MAY 2 1969</b>  |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |

00108

CONFIDENTIAL

1010 K Oak Hill Ave.

Memphis, Tennessee

Guest Book in Library, Great Chapel

MAY 2 1962

W. R. MAY 2 1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 06101   |  |  |  |  |  |   |  |  |   | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201     |  |                        |  |  |  |  |  |  |  | 06097    |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|---|--|--|---|---|--|------------------------|--|--|--|--|--|--|--|----------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print)  |  |  |  |  |  |   |  |  |   | 2a. DATE OF DEATH   |  |                        |  |  |  |  |  |  |  | 2b. HOUR |  |  |  |  |  |  |  |  |  |
| First Middle Last<br>Noy 2 Barkdoll Wiles   |  |  |  |  |  |   |  |  |   | Month Day Year<br>April 2 1969  |  |                        |  |  |  |  |  |  |  | 8 a. M.  |  |  |  |  |  |  |  |  |  |
| 3. SEX  |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH  |  |  | 6. AGE (In years last birthday)                                     |   |  | IF UNDER 1 YEAR        |  |  | IF UNDER 24 HRS.   |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| Female  |  |  | White  |  |  | Feb. 2, 1887  |  |  | 82 YRS.   |   |  | MONTHS DAYS            |  |  | HOURS MIN.   |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH  |   |  |                        |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| Maryland  |  |  | U.S.A.   |  |  |   |  |  | Washington Md.  |   |  |                        |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |   |  |                        |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| Hagerstown  |  |  | Garlock Nursing Home   |  |  | Housewife   |  |  |   |   |  |                        |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)   |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?  |   |  | 13e. STREET AND NUMBER |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| STATE Maryland  |  |  | Washington   |  |  | Smithsburg  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |                        |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME   |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |   |  |  |   |   |  |                        |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| First Middle Last<br>William F. Barkdoll  |  |  |  |  | First Middle Last<br>Susan Fitz  |   |  |  |   |   |  |                        |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown   |  |  |  |  | 16b. SOCIAL SECURITY NO.   |   |  |  |   | 17. INFORMANT   |  |                        |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| no  |  |  |  |  | 220-10-3710B   |   |  |  |   | Mr. John R. Wiles Smithsburg, Md.   |  |                        |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebral thrombosis<br>4124 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Generalized arteriosclerotic cardiovascular disease.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |   |  |  |   |   |  |                        |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 weeks<br>10 years          |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |   |  |  |   |   |  |                        |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |  |  |   | 20a. AUTOPSY?   |  |                        |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?         |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |   |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |                        |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |   |  |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |                        |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   |  |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |  |                        |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |   |  |  |   |   |  |                        |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-30, 1956, to 4-2, 1969, that (I) (we) last saw the deceased alive on 3-26, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |  |   |   |  |                        |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Charles F. Hess, M.D.   |  |  |  |  |  |   |  |  |   | 22c. DATE SIGNED<br>4-2-69  |  |                        |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Charles F. Hess, M.D.   |  |  |  |  |  |   |  |  |   | 22e. ADDRESS<br>Smithsburg, Maryland 21783                                      |  |                        |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial   |  |  |  |  | 23b. DATE<br>4/5/1969  |   |  |  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Smithsburg                                |  |                        |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Smithsburg, Washington, Md. |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Waynesboro, Penna.  |  |  |  |  |  |   |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE APR 7 1969                                      |  |                        |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                                  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |                          |  |   |  |  |  |
|--|--|--|--------------------------|--|---|--|--|--|
| 06102  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |                          |  |   | 06098  |  |  |
| CERTIFICATE OF DEATH   |  |  |                          |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First                    | Middle   | Last  | 2a. DATE OF DEATH<br>Month Day Year  |  | 2b. HOUR   |
| SARAH  |  |  | FRANCE                   | WILEY  | April 5, 1969   |  | M  |  |
| 3. SEX   |  | 4. RACE  |                          | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN   |
| Female   |  | White  |                          | March 19, 1912   |   | 57 YRS.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  | Md.  |
| Maryland   |  | U.S.A.   |                          |  |   | Washington   |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| Hagerstown   |  | 432 W. Franklin St.  |                          | Sale Lady  |   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE  |  | 13b. COUNTY  |                          | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER   |
| Maryland   |  | Washington   |                          | Hagerstown   |   |  |  | 432 W. Franklin St.  |
| 14. FATHER'S NAME  |  |  | First                    | Middle   | Last  | 15. MOTHER'S MAIDEN NAME First Middle Last   |  |  |
| Charles Brillhart  |  |  |                          |  |   | Lena E. Manahan  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO. |  | 17. INFORMANT   |  |  | Address  |
| No   |  |  | 214-09-4403              |  | Hagerstown, Md.   |  |  | Miss Suzanne Hetzer 106 Syress St.   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u><br>174X DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of breast</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u>   |  |  |                          |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 year</u><br><u>15 years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |                          |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| Oct 1954   |  | Radical Left breast  |                          |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19                   |                          |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                          |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |  |  |  |
|  |  |  |                          |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>54</u> , to <u>April 5</u> , 19 <u>69</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>April 5</u> , 19 <u>69</u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death. |  |  |                          |  |   |  |  |  |
| 22b. SIGNATURE   |  | 22c. DATE SIGNED   |                          |  | 22d. PHYSICIAN'S NAME (Type)  |  |  |  |
| John A. Moran M.D.   |  | 4/5/69   |                          |  | John A. Moran, M.D.   |  |  |  |
| 22e. ADDRESS   |  | 22f. ADDRESS   |                          |  |   |  |  |  |
| 215 W. Wash. St., Hagerstown, Md.  |  |  |                          |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)  |  |  |
| Burial   |  | April 8, 1969  |                          | Shanktown Cemetery   |   | Shanktown, Wash. Co. Md.   |  |  |
| 24. FUNERAL DIRECTOR   |  | Hagerstown, Md.  |                          | 25a. RECD BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE   |  |  |
| Andrew K. Coffman Funeral Home Inc   |  |  |                          | APR 8 1969   |   | [Signature]  |  |  |



00102

MINISTER OF HEALTH

1902

MARCH 19, 1912

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1969

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |         |  |                  |                                    |   |   |  |                                   |   |                              |  |  |  |
|--|--|---------|--|------------------|------------------------------------|---|---|--|-----------------------------------|---|------------------------------|--|--|--|
| 06103  |  |         |  |                  | CERTIFICATE OF DEATH               |   |   |  |                                   | 06099   |                              |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |         | First  | Middle           | Last                               | 2a. DATE OF DEATH   |   |  | 2b. HOUR                          |   |                              |  |  |  |
| Bertha Beatrice Williams   |  |         |  |                  |                                    | Month Day Year<br>April 30 1969   |   |  | M                                 |   |                              |  |  |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH |                                    |   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS    |   | IF UNDER 24 HRS<br>HOURS MIN |  |  |  |
| Female   |  | White   |  | December 3, 1891 |                                    |   | 77  |  |                                   |   |                              |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                  |                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |                                   |   |                              |  |  |  |
| West Virginia  |  |         | USA  |                  |                                    |   |   | Washington   |                                   |   |                              |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                  |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |                              |  |  |  |
| Maugansville   |  |         | Mennonite Old Peoples Home   |                  |                                    | Housekeeper   |   |  |                                   |   |                              |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |         | 13b. COUNTY  |                  | 13c. CITY OR TOWN                  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER            |   |                              |  |  |  |
| Maryland   |  |         | Washington   |                  | Maugansville                       |   |   |  | 231 Mt. View Ave.                 |   |                              |  |  |  |
| 14. FATHER'S NAME  |  |         | First  | Middle           | Last                               | 15. MOTHER'S MAIDEN NAME  |   |  | First                             | Middle  | Last                         |  |  |  |
| Jesse McDonald   |  |         |  |                  |                                    | Belle ShROUT  |   |  |                                   |   |                              |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  |         | 16b. SOCIAL SECURITY NO.   |                  |                                    | 17. INFORMANT   |   |  | Address                           |   |                              |  |  |  |
| No   |  |         | 215-44-7512A   |                  |                                    | Mrs. Vada Knott   |   |  | Box 201<br>Maugansville, Md       |   |                              |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Congestive heart failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Arteriosclerotic heart disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |         |  |                  |                                    |   |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>days<br>years |                              |  |  |  |
| MEDICAL CERTIFICATION  |  |         |  |                  |                                    |   |   |  |                                   |   |                              |  |  |  |
| 19a. DATE OF OPERATION   |  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                  |                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |   |                              |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |                                   |   |                              |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                  |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |                                   |   |                              |  |  |  |
| 22a. I certify that (I) (did) (did not) attend the deceased from 5/4/1966, to 4/30/1969, that (I) (did) (did not) see the deceased alive on 4/28/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |         |  |                  |                                    |   |   |  |                                   |   |                              |  |  |  |
| 22b. SIGNATURE<br>Howard N. Weeks  |  |         |  |                  |                                    | M.D. DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>              |   | 22c. DATE SIGNED<br>4/30/69  |                                   |   |                              |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |         |  |                  |                                    | 22e. ADDRESS  |   |  |                                   |   |                              |  |  |  |
| Howard N. Weeks  |  |         |  |                  |                                    | 580 Northern Ave., Hagerstown Md  |   |  |                                   |   |                              |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |         | 23b. DATE  |                  | 23c. NAME OF CEMETERY OR CREMATORY |   |   | 23d. LOCATION (City or Town) (County) (State)                        |                                   |   |                              |  |  |  |
| Burial   |  |         | 5/2/69   |                  | Glendale Cemetery                  |   |   | Flintstone Allegany Maryland   |                                   |   |                              |  |  |  |
| 24. FUNERAL DIRECTOR   |  |         |  |                  |                                    | ADDRESS   |   | 25a. REC'D BY REGISTRAR  |                                   | 25b. REGISTRAR'S SIGNATURE                                    |                              |  |  |  |
| Silcox-Merritt Funeral Service. Cumberland, Md   |  |         |  |                  |                                    | 21502   |   | MAY 5 1969   |                                   | Charles Judge   |                              |  |  |  |

00108

CERTIFICATE OF DEATH

1900 10 27 11 11 AM

1891 7 11 11 AM

1891 7 11 11 AM

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |  |  |  |   |  |
| 06104  |  |   |  |   |  |  |  |   |  |
| CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |  |
| 06100  |  |   |  |   |  |  |  |   |  |
| 1. DECEASED-NAME<br>(Type or print) <i>Loretta</i>   |  |   | First <i>Hen</i> Middle <i>Wilson</i> Last                                       |   |  | 2a. DATE OF DEATH<br>Month <i>Apr</i> Day <i>21</i> Year <i>1969</i>                         |  | 2b. HOUR<br><i>11:15P</i>   |  |
| 3. SEX<br><i>F</i>   |  | 4. RACE<br><i>Wh</i>  |  | 5. DATE OF BIRTH<br><i>11/4/95</i>  |  | 6. AGE (In years last birthday)<br><i>73</i> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <i></i> DAYS <i></i> IF UNDER 24 HRS.<br>HOURS <i></i> MIN. <i></i> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>WASHINGTON</i>  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>HAGERSTOWN</i>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>WESTERN MD. STATE HOSPITAL</i> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>housewife</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>  |  | 13b. COUNTY <i>Allegany</i>   |  | 13c. CITY OR TOWN <i>Westernport</i>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><i>424 Walnut Street</i>  |  |
| 14. FATHER'S NAME First <i>John</i> Middle <i>A.</i> Last <i>Kline</i>   |  |   | 15. MOTHER'S MAIDEN NAME First <i>Sarah</i> Middle <i>C.</i> Last <i>Saville</i> |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><i>Beulah Guy</i>  |  | Address<br><i>Westernport, Md.</i>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Lobular pneumonia</i><br><i>340x</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Multiple sclerosis</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>4d</i><br><i>10 yrs</i>                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>Generalized arteriosclerosis</i>  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br><i>19</i>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |
| 22a. I certify that <i>Edwin G Riley</i> (this hospital) attended the deceased from <i>12-10</i> 19 <i>58</i> , to <i>Apr 21</i> , 19 <i>69</i> , that (I) <i>(we)</i> last saw the deceased alive on <i>Apr 21</i> , 19 <i>69</i> , and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. <i>(I)</i> <i>(we)</i> <i>(did)</i> <i>(did not)</i> view the body after death. |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Edwin G Riley</i>   |  | DEGREE<br><i>Edwin G Riley, M.D.</i>  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  | 22c. DATE SIGNED<br><i>Apr 21, 1969</i>  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>Edwin G Riley</i>   |  | 22e. ADDRESS<br><i>1500 Penna, Hagerstown, Md</i>   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  | 23b. DATE<br><i>4/25/69</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Philos Cem.</i>  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Westernport Allegany Md.</i>             |  |   |  |
| 24. FUNERAL DIRECTOR<br><i>Edwin G Riley</i>   |  |   |  | ADDRESS<br><i>Westernport, Md.</i>  |  | 25a. REC'D BY REGISTRAR<br><i>APR 24 1969</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |

06102

Multiple sclerosis  
lobular pneumonia

Genitourinary arteriosclerosis

Chronic Bronchitis  
Edwin G. Rhy  
1500 Pennsylvania Ave  
April 21, 1944



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 06105   |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |  | 06101   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|-------------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH   |  |  |  |  |  |  |  |  |  | 2b. HOUR  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| Edna Sophia Wooden  |  |  |  |  |  |  |  |  |  | 4 Month 2 Day 69 Year   |  |  |  |  |  |  |  |  |  | M   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>female  |  |  |  |  |  |  |  |  |  | 4. RACE<br>white  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH<br>7-14-1886   |  |  |  |  |  |  |  |  |  | 6. AGE (in years<br>last birthday)<br>82 YRS.   |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN    |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS.<br>HOURS MIN |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Md.   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH<br>Washington Md.  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Hagerstown   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Wash. Co. Hospital                                     |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>clerk   |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Dept. Store   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Md.   |  |  |  |  |  |  |  |  |  | 13b. COUNTY<br>Wash.  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN<br>Hagerstown   |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER<br>32 S. Cannon Ave. |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br>William F. Cramer   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Rebecca Semler   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br>no   |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>214-09-7563A  |  |  |  |  |  |  |  |  |  | 17. INFORMANT<br>Address<br>Miss Doris Wooden, Hagerstown, Md.  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4370 Arteriosclerotic cerebro vascular Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Arteriosclerosis - Gen.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Arterio lerne phro sclerosis -<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 yr.<br>10 yrs.<br>5 yrs.  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>Arteriosclerotic Heart Disease  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, etc.)<br>OFFICE BUILDING, ETC.  |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb - 1950, to April 2, 1969, that (I) (we) last saw the deceased alive on April 2, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Charles A. Hoffman  |  |  |  |  |  |  |  |  |  | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED<br>4/4/69  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Lloyd A. Hoffman  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS<br>214 N. Potomac St. Hagerstown, Md.  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>burial   |  |  |  |  |  |  |  |  |  | 23b. DATE<br>4-5-69   |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Rose Hill Cemetery  |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Hagerstown, Md.                                |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Minnich Funeral Home Hagerstown, Md.  |  |  |  |  |  |  |  |  |  | ADDRESS   |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE APR 7 1969  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |



06103



Johns Hopkins

7-14-1980

7-14-1980

No.

Harvard

Harvard

No.

William J. Bennett

William J. Bennett

No.

7-14-1980

7-14-1980  
Johns Hopkins  
No. 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 1X69

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |   |   |   |  |   |                                   |  |
|--|--|---|---|---|---|--|---|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |   |   |   |  |   |                                   |  |
| CERTIFICATE OF DEATH   |  |   |   |   |   |  |   |                                   |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |   | First Middle Last   |   |   | 2a. DATE OF DEATH<br>Month Day Year  |   |                                   | 2b. HOUR AM  |
| CHARLES SYLVESTER YOUNG  |  |   |   |   |   | April 19 1969  |   |                                   | 11.25  |
| 3. SEX   |  | 4. RACE   |   | 5. DATE OF BIRTH  |   | 6. AGE (In years<br>last birthday)   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS |  |
| Male   |  | White   |   | June 21 1920  |   | 48 YRS.  |   |                                   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |   |                                   | Md.  |
| Maryland   |  | USA   |   |   |   | Washington   |   |                                   |  |
| 10. CITY OR TOWN OF DEATH  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |   |                                   | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |
| Hagerstown   |  |   | Wash County Hospital  |   |   | Warehouse Foreman  |   |                                   |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE   |  |   | 13b. CITY OR TOWN   |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER  |                                   |  |
| Maryland   |  |   | Washington  |   | Hagerstown  |  | 143 So Locust St  |                                   |  |
| 14. FATHER'S NAME<br>First Middle Last   |  |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last                                   |   |   |  |   |                                   |  |
| Ira L. Young   |  |   | Clara Shaw  |   |   |  |   |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)  |  |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT   |  | Address   |                                   |  |
| Yes  |  |   | W.W.#2  |   | Ira L. Young  |  | 400 Michigan Ave  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u><br>4123 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. (b) <u>atrial fibrillation</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>arteriosclerotic Heart Disease</u> |  |   |   |   |   |  |   |                                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>4 hours<br>4 yrs.<br>4 yrs. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Pulmonary Embolism; Coronary Heart Disease</u>  |  |   |   |   |   |  |   |                                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |   |                                   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |   |                                   |  |
|  |  |   |   |   |   |  |   |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/24/69</u> to <u>4/19/69</u> , that (I) (we) lost<br>saw the deceased alive on <u>4/19/69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |   |  |   |                                   |  |
| 22b. SIGNATURE<br><u>Edson B. Moody</u>  |  |   |   |   | 22c. DATE SIGNED  |  |   |                                   |  |
| 22d. PHYSICIAN'S<br>NAME (Type) Edson B. Moody, M.D.   |  |   |   |   | 22e. ADDRESS<br>363 A. Cleveland Ave. Hagerstown, Md.   |  |   |                                   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)  |   |                                   |  |
| Burial   |  | 4/23/69   |   | Rest Haven Cemetery   |   | Hagerstown Wash Co Md.   |   |                                   |  |
| 24. FUNERAL DIRECTOR<br>Andrew K. Coffmann   |  |   |   |   | 25a. REC'D BY REGISTRAR<br>DATE APR 24 1969   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                      |                                   |  |

08103

DEPARTMENT OF JUSTICE

UNITED STATES OF AMERICA

CHARLES J. YOUNG

April 19 1954

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Wife June 21 1950

Washington

Washington D.C. 20540

Washington D.C. 20540

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Washington D.C. 20540

Washington D.C. 20540

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115-14  
45M - 1-69

|  |  |   |  |  |                                    |   |   |  |                                       |  |        |
|--|--|---|--|--|------------------------------------|---|---|--|---------------------------------------|--|--------|
| 06107  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  |  |                                    | 06103   |   |  |                                       |  |        |
| CERTIFICATE OF DEATH   |  |   |  |  |                                    |   |   |  |                                       |  |        |
| 1. DECEASED-NAME<br>(Type or print)  |  |   | First  | Middle   | Lost                               | 2a. DATE OF DEATH   |   | 2b. HOUR   |                                       |  |        |
| Alice Elizabeth Zimmerman  |  |   |  |  |                                    | Month April Day 27 Year 1969  |   | M  |                                       |  |        |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH   |                                    | 6. AGE (In years last birthday)   |   | IF UNDER 1 YEAR  |                                       |  |        |
| Female   |  | White   |  | Nov. 15 1908   |                                    | 60 YRS.   |   | MONTHS DAYS HOURS MIN  |                                       |  |        |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. COUNTY OF DEATH  |   |  |                                       |  |        |
| Md.  |  | U.S.A.  |  |  |                                    | Washington  |   | Md.  |                                       |  |        |
| 10. CITY OR TOWN OF DEATH  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR INDUSTRY  |                                       |  |        |
| Hagerstown   |  |   | Washington County Hospital   |  |                                    | Co-owner Zimmerman  |   | Wholesalers  |                                       |  |        |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |   | 13b. COUNTY  |  | 13c. CITY OR TOWN                  |   | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER                |  |        |
| Maryland   |  |   | Washington   |  | Hagerstown                         |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 112 E. Washington St.                 |  |        |
| 14. FATHER'S NAME  |  |   | First  | Middle   | Lost                               | 15. MOTHER'S MAIDEN NAME  |   |  | First                                 | Middle                                       | Lost   |
| Victor   |  |   |  |  | Smith                              | Sarah   |   |  |                                       |  | Wilson |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |   | 16b. SOCIAL SECURITY NO.   |  |                                    | 17. INFORMANT   |   |  | 18. ADDRESS                           |  |        |
| No   |  |   | 218-30-7578  |  |                                    | Mr. Glen O. Zimmerman   |   |  | 112 E. Washington St. Hagerstown, Md. |  |        |
| 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |  |                                    |   |   |  |                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |        |
| PART 1. DEATH WAS CAUSED BY:   |  |   |  |  |                                    |   |   |  |                                       |  |        |
| IMMEDIATE CAUSE (a) metastatic Carcinomatosis  |  |   |  |  |                                    |   |   |  |                                       | 1 yr   |        |
| 1541 DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |                                    |   |   |  |                                       |  |        |
| (b) Carcinoma Rectum   |  |   |  |  |                                    |   |   |  |                                       | 3 yr   |        |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |   |  |  |                                    |   |   |  |                                       |  |        |
| (c)  |  |   |  |  |                                    |   |   |  |                                       |  |        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |  |                                    |   |   |  |                                       |  |        |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |                                    | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                   |                                       |  |        |
|  |  |   |  |  |                                    | YES <input type="checkbox"/> NO <input type="checkbox"/>                                |   |  |                                       |  |        |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |   | 21b. TIME OF INJURY  |  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)         |   |  |                                       |  |        |
|  |  |   | HOUR A.M. Month Day Year P.M. 19   |  |                                    |   |   |  |                                       |  |        |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |   |  |                                       |  |        |
|  |  |   |  |  |                                    |   |   |  |                                       |  |        |
| 22a. I certify that (I) (this hospital) attended the deceased from May, 1966, to April, 1967, that (I) (we) last saw the deceased alive on 4/28/69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |                                    |   |   |  |                                       |  |        |
| 22b. SIGNATURE   |  |   | Robert V. H. Campbell  |  |                                    | DEGREE ATTENDING PHYS.  |   | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. |                                       | 22c. DATE SIGNED                             |        |
|  |  |   |  |  |                                    |   |   |  |                                       | 4/28/69                                      |        |
| 22d. PHYSICIAN'S NAME (Type)   |  |   | Robert T. V. H. Campbell   |  |                                    | 22e. ADDRESS  |   | HAGERSTOWN Md.   |                                       |  |        |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |   | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |   | 23d. LOCATION (City or Town) (County) (State)                       |  |                                       |  |        |
| Burial   |  |   | April 30-69  |  | Mt. View Cemetery                  |   | Sharpsburg Wash. Co. Md.  |  |                                       |  |        |
| 24. FUNERAL DIRECTOR   |  |   | ADDRESS  |  |                                    | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE   |                                       |  |        |
| Albert L. Leaf Williamsport Md.  |  |   |  |  |                                    | MAY 1 1969  |   | James J. J. J.   |                                       |  |        |

06107

RECEIVED

U.S. DEPARTMENT OF AGRICULTURE

10

TO THE DIRECTOR, U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.  
FROM THE SECRETARY, U.S. DEPARTMENT OF AGRICULTURE  
SUBJECT: [Illegible]  
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or official communication.]

21  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06108

## CERTIFICATE OF DEATH

06104

|  |                         |  |   |  |  |
|--|-------------------------|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>David Bumberger Zook</b>   |                         |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>April 17, 1969</b>  |  | 2b. HOUR<br>4:00 P.M.  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>white</b> |  | 5. DATE OF BIRTH<br><b>Feb. 13, 1879</b>  |  | 6. AGE (In years<br>last birthday)<br><b>90</b> YRS.                     |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Penna.</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Washington</b> Md.                              |
| 10. CITY OR TOWN OF DEATH<br><b>Hagerstown</b>   |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>Wash. Co. Hospital</b> |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>machinist</b> |  |
| 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>Railroad</b>  |                         |  |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>Md.</b>   |                         | 13b. COUNTY<br><b>Wash.</b>  | 13c. CITY OR TOWN<br><b>Hagerstown</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                | 13e. STREET AND NUMBER<br><b>600 Washington Ave.</b>                     |
| 14. FATHER'S NAME First Middle Last<br><b>Jacob Zook</b>   |                         |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Annie Bumberger</b>  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown   |                         | 16b. SOCIAL SECURITY NO.<br><b>705-10-4674</b>   |   | 17. INFORMANT<br>Address<br><b>Blanche F. Zook, Hagerstown, Md.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Terminal arteriosclerotic artery disease</b><br><b>4412</b> DUE TO, OR AS A CONSEQUENCE OF <b>with abdominal aneurysm</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____ DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____ |                         |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Dehydration and malnutrition</b>  |                         |  |   |  |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                      |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |                         | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |                         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                              |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/17/1969</b> , to _____, 19____, that (I) ( <del>we</del> ) last saw the deceased alive on <b>4/17/1969</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.   |                         |  |   |  |  |
| 22b. SIGNATURE<br><b>Howard N. Weeks</b>   |                         |  |   | 22c. DATE SIGNED<br><b>4/18/69</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Howard N. Weeks, M.D.</b>   |                         |  |   | 22e. ADDRESS<br><b>580 Northern Ave., Hagerstown, Md.</b>  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>burial</b>  |                         | 23b. DATE<br><b>4-19-69</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Hill Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Wasyneshoro, Pa.</b> |
| 24. FUNERAL DIRECTOR<br><b>Minnich Funeral Home, Hagerstown, Md.</b>   |                         |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>APR 21 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                       |



